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INDEX

PAGE

A

Acrylic Resins, by J. W. Mansie .. 82
Acetoacetic Acid, by C. S. Gibson .. 246
American Officers Visit to Guy's .. 115
Amputations, The Care and Treatment of, by A. W. J. Craft 86
Appointments 114, 274
Appendicitis, Acute, by E. G. Slesinger (Clinical Lecture) 198
Awards 13, 72, 84, 165, 174, 232, 240, 241

B

Behrman, Simon, "The Frenzy" (Clinical Lecture) 124, 136
Birthday Honours 134, 154
Births 13, 26, 38, 48, 72, 84, 94, 114, 122, 134, 144, 154, 174, 186, 196, 222, 232, 240, 252
Bishop, P. M. F., Guy's in the "Blitz" 62
Blacker, C. P., Awarded George Medal 165
Blues 252
Books 95
Boxing 27
Brampton, N. P., Some Experiences of Nursing in India 203
British Dental Students' Convention .. 110
British Medical Students' Association 33
Brock, R. C., Inhaled and Swalloed Foreign Bodies 3
Bull, F. Bocquet, The Dental Curriculum 214
Bunn, H. W. 40
Burns, by Nils L. Eckhoff (Clinical Lecture) 156

C

Casualties 186, 232
Change of Address 38, 48, 60, 72, 84, 94, 114, 134, 144, 154, 174, 186, 196, 232, 240, 262, 287
Civil Defence 253
Clinical Lectures—
Simon Behrman, "The Frenzy" 124, 135
W. D. Doherty, Rupture of the Male Urethra 276
F. N. Doubleday, Some Neoplasms of the Maxillæ 118
Nils L. Eckhoff, Burns 156
A. D. Marston, Two Clinical Cases and a Description of Trichlorethylene 30
A. A. Osman, Extra-Renal Uræmia 228
E. G. Slesinger, Acute Appendicitis 198
Acute Peritonitis 242
Clinical Period in War-time 213
To Those Entering, by A. H. Douthwaite 212
Clubs' Union 215
Conybeare, J. J., Dyspepsia in the Royal Air Force 188
Treatment of Tuberculous Pleurisy with Effusion 268
Constipation in Infancy, by N. M. Jacoby 258
Correspondence—
"A Head Nurse," Nurses and their Duties 162
H. J. B. Ackins, "Rebuilding Britain" 170
C. D. Baker, Debating Society .. 220
Dental Nursing 206
Hugh Barber, "Clinical Aspects of Tobacco Smoking" 99
Thos. Barlow, Royal Medical Benevolent Fund 238
F. S. Beck, Post-War Nursing .. 9

PAGE

Correspondence—*continued.*

R. C. Brock, "Clinical Aspects of Tobacco Smoking" 99
The Late Sir William Arbuthnot Lane 250
P. J. Calvocoressi and G. M. Mavrogordato, Proposed Lambrinudi Memorial 152
"Carfax," Hospital Information .. 80
Brooke Churchill, A Correction to "Uncle Harry" 131
J. J. Conybeare, Post-War Reconstruction of Guy's 29
Rugger Centenary Dance .. 260
J. C. Crook, Patients and the Case Reports 248
Jocelyne Cuming, Nurses and Rushcliffe Report, ... 80
Robert Cutler, Rugger Centenary Dance 260
C. Davies, Letter from Germany .. 9
S. H. Daukes, *Pictures of Diseases* .. 92
D. Douglas Derrick, Dental Students' Convention 111
G. W. Dryland, "Clinical Aspects of Tobacco Smoking" 98
Ex-Sister Lydia and Sister Naaman, State-Controlled Hospitals .. 111
Charles S. Gibson, Admission of Women Students 8
J. E. Giesen, Hospital Infection of Wounds 100
Gordon W. Goodhart, Admission of Women Students 21
Mary D. Goodman, Nurses and Rushcliffe Report 71
"Guy Minimus," Uncle Harry's Advice Sought 193
G. Haslewood, Rugger Centenary Dance 249
J. C. Hawkes, Nurses and Rushcliffe Repor 92
W. Archer Hodgson, Admission of Women Students 8
Arthur Hurst, The Courage of Our Convictions 249
Michael Kugler, Biological Fight for Existence 152
T. B. Layton, Admission of Women Students 7
Conduct of an Englishman .. 162
"Lethargy," To Dental Students .. 221
J. Moore, Home-Grown Drugs 131, 224
National War Formulary .. 250
Ian A. H. Munro, Nurses and their Duties 170
E. G. Murphy, J. F. Dudley, S. F. Tizzard, A. S. Dixon, The Guy's Branch of the S.M.A. 112
W. H. Ogilvie, Medical Examination Answer 101
Priscilla Joseph (née Carbonall), R.A.F. Gremlins 153
Several Signatories, Nurses and their Duties 170
Clive L. Sharp, Pictures of Disease 58
E. G. Slesinger, Rugger Centenary Dance 280
M. E. N. Smith, Guy's Men and the *Gazette* 152
W. R. Spurrell, *Re* Sector Letters .. 143
The Staff of the Eye Ward, Gremkins in Guy's Hospital 143
"Stanley."—State Registered Dental Nurses 171
"Synoptic."—To Dental Students 130 205
J. Robin Tanner, Increase of Salaries for Nurses 58
Florence Taylor, Student Nurses' Fees 79

PAGE

Correspondence—*continued.*
I. T. The, Borrowing Periodicals .. 237
"Uncle Harry," Pictures of Disease 71
Re Four Cases of Epilepsy .. 117
Replies to "Guy Minimus" .. 204
May K. Wilks, Post-War Reconstruction 220
S. H. Wass, Rugger Centenary Dance 261
Several Contributors, Use of Library 23
Courage of our Convictions, by D. W. James 236
Craft, A. W. J., The Care and Treatment of Amputations 86
Croonian Lecture, by C. P. Symonds.. 115
Cricket 197
Retrospect 1943 221
v. Beckenham 154
v. Malden Wanderers 186
v. Metropolitan Police .. 123, 164, 195
v. Middlesex Hospital .. 153, 186
v. N.F.S., London 164
v. Old Rutlishians 164
v. Overseas H.Q., R.A.A.F. 134
v. Public School Wanderers .. 114
v. Richmond 195
v. St. Bart.'s Hospital 173
v. St. Mary's Hospital 194
v. St. Thomas's Hospital .. 154, 195
v. Woolwich Garrison 134

D

Dance, Dental School 232
Rugby Football Centenary 240
Davies, E. R. 233
Death Certificate, by Keith Simpson.. 51
Death consequent upon an Epileptic Fit, by A. Churton Taylor 191
Deaths 26, 38, 48, 60, 72, 84, 94, 114, 122, 144, 154, 186, 196, 208, 222, 232, 262, 274, 287
Dental Conservation, Notes on, by A. R. F. Thompson 44
Curriculum, by F. Bocquet Bull .. 214
School Annual Dance 232
List of Entries 231
Prize Examinations 232
Society, Presidential Address .. 254
Dig for Victory 155
Doctor's Dream 278
Doherty, W. D., Elected President of the Rugby Football Club 135
Rupture of the Male Urethra (Clinical Lecture) 276
Doubleday, F. N., Some Neoplasms of the Maxillæ 118
To Those Entering the Clinical Period 212
Dramatic Society, Ten-Minute Alibi .. 286
Durham, Arthur Edward 141
Dyspepsia in the Royal Air Force, by J. J. Conybeare 188

E

Eason, H. L., Infamous Conduct in a Professional Respect .. 115, 147
Knighthood Bestowed 123
Eckhoff, Nils L., Burns (Clinical Lecture) 156
Infections of the Hand 67
Recent Advances 234
El Kakim Kebir Pasha, Enlargement of the Spleen 183
Entries, New 231
Epilepsy, Four Cases of, by H. F. Lunn 96
Epileptic Fit, Death consequent upon, by A. Churton Taylor 191
Evans, Surg.-Lieut. P. R. C., Heroic Deed in Treatment of Survivors.. 85
Awarded George Medal 223
Examinations. See Pass List
Extractions, by K. E. Pringle.. .. 254
Eye, Syphilitic Affections of, by Frank W. Law 17

F

PAGE

Farnborough Letter 7, 273
Football, Association 25, 115, 251
Review of Season, 1942–43 113
v. Charing Cross and R.D.H. .. 274
v. London Hospital 274
v. University College Hospital .. 285
Rugby 197
Centenary Celebrations 135, 240, 241, 271
Centenary Match 263
Dance 240
Fixtures, 1943–44 207
Prospects 207
Review of Season 1942–43 .. 121
v. Aldershot Services .. 12, 71
v Bedford 72
v. Cambridge University 37
v. Coventry 251
v. Eastern Command 59
v. H.M.S. *Daedalus* 59
v. London District 93
v. London Rugby Union (Centenary Match) 271
v. Metropolitan Police 59
Middlesex County Seven-a-Side .. 106
v. Middlesex Hospital .. 37, 239
Past and Present 146, 230
v. Rosslyn Park 12, 93
v. Royal Naval Engineering College 12
v. Royal New Zealand Air Force .. 37
v. Royal Navy, Portsmouth .. 37
Rugby School Past and Present 261, 285
v. Rugbeians Past and Present .. 285
v. St. Bart.'s Hospital 12, 25
v. St. Mary's Hospital 71
v. St. Thomas's Hospital 261
United Hospitals Seven-a-Side Competition 105
v. Wasps 93
Foreign Bodies, Inhaled and Swallowed 3
Fourman, Paul, Appointed Medical Tutor 27
Freemantle, Sir Francis, Death of .. 187
Obituary 210
"Frenzy," The, by Simon Behrman (Clinical Lecture) 124, 136
Front Surgery; or Advice to Dressers 141

G

Gayer-Anderson, Major R. G., Gift of a House to Surrey County Council.. 2
Gibson, C. S., Acetoacetic Acid .. 246
"G. L. D.", "The Literature" .. 146
Golding-Bird Medal in Bacteriology .. 208
in Obstetrics and Gynæcology .. 208
Gover, P. A., Experimental Studies in Leukæmia and Allied Conditions .. 166
Guy's Hospital, Air-Raids of 1940–41 95
During the Alert 27
In the "Blitz," by P. M. F. Bishop 62
Gazette 145
J. O. Law appointed Editor .. 27
H. B. F. Ordish resigns Editorship 27
Medical School, List of Entries .. 231
Prize Examination Awards 94, 240
Guy's Letter 6, 57, 81, 101, 129, 163, 194, 259
Guy's Odd Ode No. 1 286

H

Hallam, John W., The Inferior Alveolar Nerve and the Fractured Mandible.. 22
Hand, Infections of, by Nils L. Eckhoff 67
Hardy, T. L., Clinical Aspects of Tobacco Smoking 74
Harries, Wing-Cmdr. R. H., Awarded D.S.O. 241
Health Problems 41
Health of Students 187

PAGE

Hockey—
v. King's College Hospital 285
v. London Hospital 285
v. Middlesex Hospital 251
v. St. Bart.'s Hospital 38
v. St. Mary's Hospital .. 25, 59, 273
v. University College Hospital .. 59
v. Westminster Hospital 251
Honours, Birthday 134, 154
Hopson, M. F., Death of 27
Obituary 41
Hurst, Sir Arthur, The Hysterical Nature of So-called Pernicious Vomiting of Pregnancy 225
Hurstmead Letter 129

I

Illustrations—
Guy's Hospital R.F.C. 284
Incident Room 197
India, Nursing in, by N. P. Brampton 203
Infamous Conduct in a Professional Respect, by Sir Herbert L. Eason.. 147
Infancy, Constipation in, by N. M. Jacoby 258
Infections of the Hand, by Nils L. Eckhoff 67
Inferior Alveolar Nerve and the Fractured Mandible, by John W. Hallam 22

J

Jacobsoniana 47, 113, 172
Jacoby, N. M., Constipation in Infancy 258
When, How and When Not to Use Sulphonamides 181
James, D. W., The Courage of Our Convictions 236
Junior's Lament 185

K

Killed in Action 26, 40

L

Lambrinudi, C., Death of 95
Tributes 98, 116
Lane, Sir W. Arbuthnot, Obituary .. 28
Large, P. G., Awarded Treasurer's Medal and Prize in Clinical Surgery 287
Law, Frank W., The Functions of a Specialist 264
Syphilitic Affections of the Eye .. 17
Lawn Tennis Club 222
Laws, J. O., Appointed Editor of the *Gazette* 27
Leonard Lubbock Prize in Clinical Pathology 208
Letters to My Nephew, by "Uncle Harry" 56, 108
Letters from "Sinbad" .. 269, 281
Leukæmia and Allied Conditions, Experimental Studies on, by P. A. Gorer 166
Lewis, T. L. T., Awarded Treasurer's Medal and Prize for Clinical Medicine 252
"Literature," The, by "G. L. D." .. 146
Lunn, H. F., Four Cases of Epilepsy.. 96

M

Mandible, Fractured, The Inferior Alveolar Nerve and, by John W. Hallam 22
Marriages 26, 38, 84, 114, 122, 134, 174, 196, 208, 222, 232, 287
Mansie, J. W., Acrylic Resins 82
Marston, A. D., Two Clinical Cases and a Description of Trichlorethylene (Clinical Lecture) 30
Maxillæ, Some Neoplasms of, by F. N. Doubleday 118

PAGE

Medical Education 49, 123, 135
At Guy's Hospital 1
Legislation 73
Tutor, Paul Forman Appointed .. 27
Mentioned in Dispatches 26, 38, 60, 186, 232, 252, 274
Missing 13, 48, 252, 262
Mullins, M. R., Returns to South Africa 40
Mythozoa, A Short Survey of, by Sir Robert Synjann 104
Mythozoology, by Sir Harley Wimpole 133

N

National Association for the Prevention of Tuberculosis 175
National Service 253
War Formulary 223
Nerve, Inferior Alveolor, and the Fractured Mandible, by John W. Hallam 22
New Year's Honours 26
Notices, Acting Medical Registrar .. 252
Demonstrator of Anatomy 252
Dental School, Appointment of Demonstrator in the Department of Conservative Dental Surgery .. 287
Dental Society 222
Dramatic Society 262
Examinations 186
Guy's Hospital Ladies' Association 144
Letter from a Patient 84
Midwifery Registrar 106
Nuffield House, Reception of Patients 154
Resident Medical Officer 154
Postural and Remedial Exercises .. 38
Return of *Gazettes* 94
Rugby Football on Rugby School Close 240
Text-book of Pharmacology .. 274
Treasurer's Medal and Prize for Clinical Medicine 252
U.S. Government Office of War Information 208
Nurse as Citizen 16
Nursing in India, by N. P. Brampton.. 203
Profession, To Those Entering .. 214

O

Obituary, Sir Francis Freemantle .. 210
Montagu F. Hopson 41
C. Lambrinudi 95, 98, 116
Sir W. Arbuthnot Lane 28
Cecil Price-Jones 224
R. W. Robbins 2
N. A. Dyce Sharp 2
Ogilvie, W. H., General Principles of War Surgery 176
Promoted Major-General 187
Ordish, H. B. F., Resigns Editorial of *Gazette* 27
Orpington Letter 163
Osler, Sir William, Sayings and Quotations of .. 20, 35, 94, 144, 194, 206
Osman, A. A., Extra-Renal Uræmia (Clinical Letter) 228
Papers by Guy's Men 26, 60, 91, 114, 164, 186, 195, 240, 262, 274

P

Park, The 49
Passim 1, 15, 27, 41, 49, 61, 73, 85, 95, 107, 115, 123, 135, 145, 155, 165, 175, 187, 197, 209, 223, 233, 241, 253, 263, 275
Pass List—
Conjoint .. 48, 94, 134, 144, 174, 208, 222, 252, 287
Royal College of Physicians, M.R.C.P. 48, 114, 122, 186
Royal College of Surgeons, F.R.C.S. 13, 114, 287
L.D.S. .. 25, 84, 154, 252, 262

PAGE

Pass List—*continued.*
Society of Apothecaries of London 48, 60, 84, 106, 114, 134, 196, 240, 274
University of Cambridge, M.B., B.Ch. 144, 287
University of London, B.D.S. 25, 26, 196
Diploma in Clinical Pathology .. 38
M.B., B.S. 25, 60, 94, 134, 208, 232, 262
M.D. 26, 186
University of Oxford, B.M., B.Ch... 26, 164
Pembury Letter 43
Peritonitis, Acute, by E. G. Slesinger (Clinical Lecture) 242
Picture of Diseases 61
Pleurisy, Tuberculous, with Effusion, Treatment of, by J. J. Conybeare .. 268
Pope, Audrey, Awarded *Nursing Times* Prize for Essay 15
Postural and Remedial Exercises .. 38
Pregnancy, Hysterical Vomiting of, by D. W. James 236
Vomiting in, by Sir Arthur Hurst .. 225
Pringle, K. E., Extractions 254
Prisoner-of-War .. 13, 48, 60, 84, 114, 196, 232
Appeal for Rugger Kit 15, 40
Prize Examination Awards—
Guy's Hospital Medical School 94, 240
Dental School 232
Treasurer's Medal and Prize in Clinical Medicine 252
Treasurer's Medal and Prize in Clinical Surgery 287

R

Recent Advances, by Nils L. Eckhoff.. 234
Reviews—
Bailey: Pye's Surgical Handicraft.. 10
Barber: Tropical Diseases and Sub-Tropical Diseases 11
Beaumont: A Pocket Medicine .. 11
Berkeley: A Text-book of Gynæcological Surgery 103
Blacker: Notes for the R.M.O. of an Infantry Unit 239
Braithwaite: Infant Feeding in General Practice 102
Burn: Whitla's Pharmacy, Materia Medica and Therapeutics 153
Conybeare: Medicine 36
Crawford: Materia Medica for Nurses 23
Douthwaite: Hale-White Materia Medica 42
Fairbrother: A Text-book of Bacteriology 24
Farquharson: Illustrations of Surgical Treatment 104
Garrison and Morton: A Medical Bibliography 219
Glaister: Medical Jurisprudence and Toxicology 10
Halliburton and McDowall: Handbook of Physiology and Biochemistry 10
Handfield-Jones and Porritt: The Essentials of Modern Surgery .. 239
Illingworth: Text-book of Surgical Treatment, including Operative Surgery 24
Johnston: Regional Anatomy .. 216
Jones: Design and Purpose .. 217
Habit and Heritage 103
Macintosh and Bannister: Essentials of General Anæsthesia 104
Mackie and McCartney: Handbook of Practical Bacteriology 23
Maingot, Slesinger and Fletcher: War Wounds and Injuries .. 184
Marrack: Food and Planning .. 113
Morton: Prescriptions and How to Read Them 23
Ogilvie: Pathological Histology .. 220

PAGE

Reviews—*continued.*
Pearce: A Complete Handbook of Hygiene in Questions and Answers 173
Fevers and Fever Nursing .. 173
Peel: Forsdike's Text-book of Gynæcology 283
Riddell, Lectures to Nurses .. 23
Rolleston and Moncrieff (Editors): After-Care and Rehabilitation .. 217
Fractures and Dislocations .. 101
Rose and Carless, Ed. Wakeley: Manual of Surgery 217
Stevenson: The Ear, Nose and Throat in the Services 219
Sutherland: First Aid 173
Sears: Materia Medica for Nurses.. 185
Ten Teachers: Midwifery 22
Trail: Chest Examination 283
Trueta: The Principles and Practice of War Surgery 102
Turner: Modern Operative Surgery (Carson's) 184
Wlashe: Diseases of the Nervous System 219
Wansborough: Dietetics 23
Waterfield: The Revolving Heavens 102
Yellowlees: Out of Working Hours 103
Robbins, R. W., Obituary 2
Rowing, Inter-Hospitals Regatta .. 174
Royal Air Force, Dyspepsia in, by J. J. Conybeare 188
Royal College of Surgeons 165
Rumsey, H. St. John, Clear Speech .. 201
Rupture of the Male Urethra, by W. D. Doherty (Clinical Lecture) 276
Ryle, Professor J. A., Appointed Professor of Social Medicine at Oxford University 16

S

Sayings and Quotations of Sir William Osler 20, 35, 94, 144, 194, 206
Sharp, N. A. Dyce, Obituary 2
Sicily, Extract from a Letter received from 193
Simpson, Keith, The Death Certificate 51
"Sinbad," Letters from .. 269, 281
Slesinger, E. G., Acute Appendicitis .. 198
Acute Peritonitis (Clinical Lecture).. 24
Specialist, Functions of, by Frank W. Law 264
Speech, Clear, by H. St. John Rumsey 201
Spleen, Enlargement of, by El Hakim Kebir Pasha 183
Starlets Revue 248
Students, Health of 187
Sulphonamides, The Use and Abuse of (Editorial) 85
When, How and When Not to Use, by N. M. Jacoby 181
Surgery, War, General Principles of, by W. H. Ogilvie 176
Symonds, C. P., Croonian Lecture .. 115
Syphilitic Affections of the Eye, by Frank W. Law 17
Synjann, Sir Robert, A Short Survey of the Mythozoa 104

T

Taylor, A. Churton, Two Interesting Cases of Death both consequent upon an Epileptic Fit 191
"Ten-Minute Alibi" at Tunbridge Wells 286
"The Literature," by "G. L. D." .. 146
Thompson, A. R. F., Notes on Dental Conservation 44
"Those Medical Bulletins," 35
Treasurer's Gold Medal and Prize in Clinical Medicine 252
In Clinical Surgery 287

PAGE

Trichlorethylene, Description of, Two Clinical Cases and, by A. D. Marston (Clinical Lecture) 30
Trounce, J. R., Honours in University of London, M.B., B.S., Examination 253
Tuberculosis 107, 175
Tuberculous Pleurisy with Effusion, Treatment of, by J. J. Conybeare .. 268

U

"Uncle Harry," Letters ro My Nephew 56, 108
University of London, Examiners in Subjects for Medcal Degrees .. 13
M.B., B.S. Examinations, Honours Award 253
Senior Training Corps 253
Uræmia, Extra-Renal, by A. A. Osman. (Clinical Lesture) 228

PAGE

Urethra, Male, Rupture of, by W. D. Doherty (Clinical Lecture) 276

V

Vomiting of Pregnancy, by Air Arthur Hurst 225
Hysterical, by D. W. James .. 236

W

War Surgery, General Principles in, by W. H. Ogilvie 176
War-Time, Clinical Period in 213
Whatley, John, Killed in Action .. 40
Wilks, Sir Samuel 119
Wimploe, Sir Harley 133
Women Students, Admission of .. 15

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PASSIM

MAY we take this opportunity, the first in the New Year, to wish all our readers, and particularly all Guy's people, wherever they may be, the pleasantest of successes and the accomplishment of what must be our outstanding aim for 1943—a Victorious Peace.

Although we have tried to record each event of importance in these columns as the year's weeks roll by, several outstanding things seem to have been missed, and, perhaps, it would be of interest to try and recall those events of the past year which stand out in our minds, and to see how other improvements and changes at Guy's have progressed since we recorded them. We think the outstanding thing of this past year is the way in which the teaching at Guy's has kept up to the old standards in spite of many difficulties, and in spite of the great inroads made on the staff by the calls of the Services. The Junior Staff Committee is also a new innovation, and they have a say in the School Council. The call-up of newly-qualified men has so affected the house appointments that three or six months is the usual length of time to be expected after qualifying before being called up. The consequence of this is that the number of student housemen has been raised. The supply of secretaries has also been increased, and now, as well as the answers to doctors' letters being typed, houseman's reports are also capable of being interpreted in a few years' time.

And, of course, we must not forget to mention our new Sub-Dean, although we have got so used to the pleasure of Mr. Doherty's appointment.

To come back to scholastic work, the clinical time has been reduced to conform with the new regulations of the M.B., and it is now possible for people to qualify after thirty months of clinical work. We mentioned some time ago that ward rounds and the Out-patient departments were very crowded—they still are—but some reduction has been made in the crowds by limiting some rounds to particular firms. Pembury now is deserted by all except the obstetric dressers and a children's firm, and Farnborough and Guy's have absorbed the preclinicals and ward-clerks. The school at Tunbridge Wells is still going strong. Also taking part in the migration back to Guy's is the Dental School, which has almost entirely deserted Sherwood Park. May we express the fervent hope that soon Guy's will envelop once more the whole of the Medical School. Meanwhile, at Guy's, the second floor of Hunt's House was opened up and then the new staircase began to grow still higher and now reaches the third floor.

Another new thing started last year was the system of appointments for out-patients. This has worked very well on the whole, and we are sure that patients appreciate the fact that although teaching must be done, their time is considered and we do all we can to make their journey through the hospital as expeditious as possible. Another help in this direction is that given by the Dispensary; patients may now leave a bottle and their prescriptions and then return later to collect their medicine. One small matter: patients come up to Guy's with a doctor's letter sometimes from a very far distance with no arranged appointment; if they could telephone and book a time before making their journey many of them would find that a lot of time would be saved. The cards given to war-workers are also helping them to spend as little time as possible in waiting.

We must also have a word of praise for the College Catering Staff; they have done exceedingly well considering the difficulties under which they work. Christmas especially saw a fare which would not have disgraced a peace-time table.

And, of course, in war-time we ourselves have contributed by adopting a smaller page and a smaller print. We must not forget to mention the Roll of Honour and the Roll of War Service, which the *Gazette* hopes to keep as up to date as possible. This

may be helped by the plan we mentioned some weeks ago—a book which is kept in the Superintendent's Office and in which we hope every old Guy's man will inscribe his name and address whenever he visits the hospital.

Our very sincerest thanks are due to those who have contributed to the scheme, "Grow Greens for Guy's"; we hear that over twenty tons have already been received by the Hospital.

It may be of interest to Guy's men to know that Major R. G. Gayer-Anderson and his brother intend to make a gift of their lovely country house, The Little Hall, an early fifteenth century house at Lavenham, Suffolk, to the Surrey County Council. The house, which contains two studios, is intended as a hostel for young art students. Major Gayer-Anderson has spent a long time in Egypt, where he has left a beautiful old Arab home which is to be made into a living national museum.

We regret to learn that Dr. Walter Welchman, M.B., F.R.C.S., has died in Johannesburg. He was the senior surgeon at the Johannesburg General Hospital and lecturer at Witwatersrand University. He qualified here in 1905. He was sixty-one years of age.

Obituary

N. A. DYCE SHARP.

DR. DYCE SHARP was a man that Guy's may well be proud of; he had special interests inside the realm of medicine and also others of value outside it. It must have been about the year 1926 that I first came in contact with him; he was then in the Government Medical Service of Nigeria, while I was conservator of the Museum of the Royal College of Surgeons, Lincoln's Inn Fields. He was a shy man, reserved and very modest-minded of his ability, which impressed me very much. He had become interested in gorillas and chimpanzees which were inhabitants of the forests in the Nigerian Province in which he was stationed. He made a collection of gorilla skulls—forty in number—which he presented to the College of Surgeons. His observations on the habits of the gorilla—made as he tracked them in their native forests—were published in the *Proceedings of the Zoological Society of London for* 1929—if my memory may be relied on; while my account of the collection of gorilla skulls, given by him to the Royal College of Surgeons, appeared in *Nature*, 1927, vol. 120, p. 914. He had a great public spirit.

Here is a little extract from the Conservators' Report (R.C.S.) for 1928:—"Many important additions have been made to the series which illustrates the osteology of the animals most akin to man in structure—the anthropoid apes. The most important donation we owe to Dr. N. Dyce Sharp. The collection of gorilla skulls (forty in number) is of great value for this reason. When we observe a high degree of individual variation in any human community, we account for it by supposing racial intermixture. There can be no question of intermixture in the gorilla population from which Dr. Dyce Sharp's skulls come, and yet there is among them an extreme degree of individual variation." All of which—to cut a long story short—goes to show that "variability" may be a character of a "pure"—not mongrel—race. I am glad to have this opportunity of paying tribute to the memory of a man bred in the public spirit of the Guy's tradition—a tradition which he truly adorned. A. K.

RANDOLPH WILLIAM ROBBINS (1871–1941).

A FERVENT natural historian since his schooldays R. W. Robbins entered the Secretary's Office at Guy's in 1887, and he continued to serve there in positions of steadily increasing responsibility, latterly as Renter Warden, until he retired in 1935. He died in August, 1941.

In several journeys to the Continent, particularly Switzerland, he discovered many an unnamed plant and insect. Absorbed, as he was, in the minutiæ of his own particular branches of natural history, he sought to keep such studies in their true perspective by maintaining a grasp of the broader principles of science in its widest ranges—and the files of the *London Naturalist* contain not a few notable articles from his pen.

Inhaled and Swallowed Foreign Bodies

By R. C. BROCK, M.S.

GENTLEMEN,—The problem of the inhaled or swallowed foreign body is one of great practical importance and, moreover, provides an interest which appeals to most of us. Although inhaled foreign bodies are, on the whole, rare, swallowed ones are quite common and, for this reason, it is necessary that you should know clearly how to deal with them. Children, especially crawlers and toddlers, are, perhaps, most often victims and, as general practitioners or in the casualty department of a hospital, you are likely to be confronted with an anxious parent or a whole household in a state of semi-uproar. Infants in arms are not immune, as they manage to pick things up or pluck them from their mother's dress; a safety-pin may drop from the mother's mouth into the baby's and be inhaled or swallowed.

DIAGNOSIS.

You are usually presented with the diagnosis, but even then the description of the foreign body may be wrong. I have had two patients who were said to have inhaled a "pea-nut" and a "piece of gristle," and in each a radiograph revealed a small open safety-pin. Never assume that the foreign body is not radio-opaque just because you have been told it is non-metallic. If possible always ask the mother or patient to produce a replica of the missing article; it may be of great assistance in considering treatment.

Again, you must never ignore or make light of a history of a swallowed foreign body; I have seen several tragedies following this mistake on the part of the doctor. Moreover, do not necessarily be unduly influenced by a negative radiological report. I was asked by a doctor to see a lady whom he suspected of having an impacted chicken bone which had stuck in her throat on the previous evening. His junior partner had been called in soon after the occurrence and had made light of the patient's fears, but on the following morning she insisted on seeing the senior partner because she had had an uncomfortable night and could barely swallow even fluids. He felt sure that the bone was lodged in the œsophagus and asked me to go to a radiologist's house, so that I could see the radiographs and the patient together. The radiologist had completed his examination and had already assured the patient that nothing was wrong; no shadow of a foreign body could be seen and he reported that barium had been swallowed with no hold-up. Actually the films showed a small but definite patch of barium retained in the œsophagus, which strongly suggested an impacted foreign body. This was quite apart from the history and visible distress of the patient, both of which made œsophagoscopy essential. I remember this case so well because the radiologist took offence at my perfectly reasonable suggestion that I was not satisfied that a foreign body had been excluded and he made it clear that he was going out of his way to impress upon the doctor by telephone that I was wrong. An attitude such as this is stupid and unnecessary because in a case in which any doubt at all exists œsophagoscopy is essentially the final method of examination. At œsophagoscopy an hour or two later I removed a large triangular piece of chicken bone measuring an inch in each direction and with sharp lethal corners.

There may be no history at all of swallowing a foreign body, for I have operated on two patients with perforation of the intestine—in one case by a piece of wood, in the other by a large fish-bone—who had no recollection of having swallowed them. In one other case I removed a large rabbit bone impacted astride the rectum, and in yet another a fish-bone from the interior of an ischio-rectal abscess, both patients being quite unaware of their ingestion. Even with a foreign body that enters the trachea there may be no history of choking or coughing, and you must be most careful not to overlook such an accident just because of the absence of these symptoms. I have observed this on several occasions and have been most careful to verify that it was so. In one case, which occurred in the Dental Department here, a large gold filling dropped straight down the trachea into a bronchus and both the dental surgeon and the patient were most emphatic that there had been no choking or coughing. This warning applies especially to the question of inhalation of a tooth or part of a tooth during extraction. It is so easy to assume that the piece has passed harmlessly down the œsophagus and to take no steps to find out if it is in the lungs. Remember that from the medico-legal point of view alone you must take proper precautions to exclude this happening.

The law will not hold you negligent if a tooth is inhaled during extraction or during anæsthesia, but it will hold you responsible if you do not *take all proper steps to investigate and to institute treatment.* You are culpable not in the act, which it is assumed was an accident occurring while you were doing something with average care and skill, but in the omission to observe the occurrence and to deal with it. Again, I have on two occasions removed a fragment of tooth from a bronchus after the patient had been assured by a dental surgeon that a missing fragment had not been inhaled, but had not had the patient radiographed nor seen by a doctor. In each case legal proceedings were instituted, but were settled out of court as there was virtually no defence at law.

In a case of suspected foreign body the patient should be radiographed from the naso-pharynx to the pelvis, although clearly you may dispense with the latter if the history is definitely one of only an hour or two. Radiography should be used even if the foreign body is definitely not radio-opaque. Thus, in the lungs you may observe atelectasis or obstructive emphysema of a lobe or of a whole lung; films should always be taken in both full inspiration and full expiration and compared. In obstructive emphysema the foreign body acts as a valve allowing air to enter during inspiration, but prevents its exit during expiration; the affected lung or lobe is thus ballooned up and the inexperienced observer may actually place the foreign body on the side opposite to that on which it really is.

A non-opaque foreign body in the œsophagus or pharynx may be revealed after radiography with barium; first, a thin emulsion should be used and then a thick cream; lastly, it may be necessary to give small pledgets of cotton-wool soaked in barium.

INHALED FOREIGN BODIES.

Larynx.—The danger from a foreign body caught up in the larynx is, of course, immediate suffocation, and every museum has specimens to illustrate this. Even if the foreign body is too small to block the air-way it may set up a fatal spasm. Immediate tracheotomy or laryngotomy may be needed. Not all laryngeal foreign bodies are rapidly fatal, for I have seen an open safety-pin impacted in the larynx which had caused but little distress, although it had been there for many hours. Remember that, in removing a foreign body from the larynx, you should have your forceps ready and grasp *at once* whatever piece of it you first see, even if it is an open safety-pin. You will do no harm by pulling it without considering its lie, whereas if you try to manœuvre you may well push it into the trachea and will then be faced with quite a different problem. Remember also that tracheotomy may be needed *after* removal of the foreign body, and so have everything ready.

Trachea.—A foreign body in the trachea may be just as dangerous as one in the larynx, for as it rests against the carina it produces an intense fit of coughing, which causes it to be shot up against the vocal cords, spasm then follows which may prove fatal. Tracheotomy or laryngotomy may, therefore, be needed urgently.

Bronchus.—Let me make it clear to you at once that, *in general*, the removal of an intra-bronchial foreign body is not necessarily an urgency, especially if it is non-vegetable. A large one in a main bronchus may be coughed up to the larynx and cause a spasm, but this is uncommon. A vegetable foreign body, especially a pea-nut, is liable to cause a severe inflammatory reaction rather quickly, but a non-vegetable one is much less irritating. It is, of course, desirable that any foreign body in a bronchus should be removed as soon as possible, but remember it is not necessarily *an urgency.* This is in contrast to the œsophagus in which a non-vegetable foreign body does constitute an urgency. The removal of a foreign body from the bronchus requires at all times a high degree of skill and care in addition to the proper instruments. I have seen tragedies occur from premature and unskilled attempts to remove intra-bronchial foreign bodies without proper instruments when a 12–24 hours' delay would have allowed a skilled operator to remove the foreign body with correct equipment. In a small baby a very high degree of skill is needed and, of course, specially small instruments, and yet I have been called urgently to see infants with inhaled metal foreign bodies on whom clumsy amateur attempts at removal had been made late at night without success. In each of these the call I received was urgent because of the moribund condition of the patient; in each because of the inevitable œdema of the glottis from the excessive trauma of a prolonged and futile manipulation. If you have a baby or small child with an inhaled foreign body do not attempt to touch it or let anyone else do so until you have *all* the *proper* instruments *and* a person capable of using them quickly and efficiently. There may be no margin for a second attempt after a long and clumsy manipulation which has failed.

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G.H.G.

The technical side of the removal of foreign bodies from the bronchus is one that need not concern us here. Very occasionally a foreign body may be pushed so far down by repeated attempts at removal that it passes beyond the reach of the most skilled bronchoscopist. I have twice had to perform open thoracotomy for the removal once of a metal paper-clip and once of a root of a molar tooth.

The secondary results of an inhaled foreign body may be serious and permanent, especially if it has been overlooked for a long time. In children especially a foreign body may pass unnoticed for months or years. In the earlier stages it gives rise to atelectasis and then a pneumonia which does not resolve. In the course of about a month I removed a foreign body (in each case a piece of nut) from three children in the children's ward of this hospital; each had been admitted as suffering from pneumonia, and it was due to the clinical astuteness of Dr. Ellis that the presence of the causal foreign body was recognised or suspected. In one of these a stricture and permanent bronchiectatic changes followed for which a lobectomy was later needed. I have had other cases in which permanent changes after removal of the foreign body demanded lobectomy.

Always be suspicious of "unresolved" pneumonia in a child; it often hides an unsuspected foreign body. The same applies to asthma. I once saw a child of nine who had suffered from severe "asthma" almost all his life, but had never been X-rayed; a radiograph showed a large nail in the left bronchus which was so carbonaceous that it fragmented during removal; the lung in this patient was totally bronchiectatic.

SWALLOWED FOREIGN BODIES.

Œsophagus.—A foreign body may stick in the œsophagus at any level, but usually does so at one of the three classical levels, the upper end, at the level of the left bronchus or at the lower end. Perhaps the commonest is the upper end, where most of the larger foreign bodies, such as coins, lodge. A foreign body impacted in the œsophagus is usually *very dangerous*, especially the sharp metallic or bony ones. The grave danger is perforation of the œsophageal wall with mediastinitis, less often penetration of a large vessel such as the aorta. Although their removal is a matter of relative urgency, a clumsy or inexpert operation increases the danger of perforation so much that it is better to delay a little while until a skilled operator can be obtained than to risk failure or a fatal complication. In general, it is best to use a method of removal under direct visual control and not blind manœuvre. The coin-catcher is permissible if used carefully and *if you are sure that it is really a coin* that is impacted. It should not be used when the coin has been in place more than a short time, as the presence of inflammation and œdema make it too dangerous. The probang is a dangerous instrument which has no place anywhere outside a museum of surgical antiquities.

The actual details of removal of œsophageal foreign bodies is again an advanced technical problem and has no place here; it is sufficient to say that in certain of the more difficult foreign bodies lodged in the lower œsophagus it may be possible and desirable to push them on into the stomach whence they are usually safely passed.

Stomach and Intestines.—Once a foreign body has entered the stomach it is much more likely to pass uneventfully than to give rise to a complication. It is very important that you should know and appreciate this for a great many entirely unnecessary operations are done for their removal and a great deal of unnecessary anxiety is engendered which could easily be allayed by a little firm and confident re-assurance. The only foreign bodies that are likely to remain in the stomach are the very large ones such as dinner forks or spoons, which are usually (and often repeatedly) swallowed by lunatics or prisoners. Almost all others pass quickly and safely through the whole length of the intestine, although they may eventually be held up in the lowest part of the rectum. Those that do stop on the way usually choose one of two levels, the second part of the duodenum or the last part of the ileum. When held up in the ileum they most commonly cause obstruction, especially the large indigestible vegetable fragments, such as pineapple pieces or large segments of orange which may become aggregated to form a big mass. An otherwise harmless foreign body such as a cherry- or plum-stone may be the cause of a final acute obstruction by becoming impacted in the constricted lumen of a carcinoma of the colon.

The two most common objects to be held up in the duodenum are an open safety-pin or a Kirby grip. This last, by the way, is a common and dangerous foreign body which is constantly being swallowed by children who place them in the mouth while

adjusting their hair. Never allow yourself to be intimidated into operating prematurely on one of these cases just because the object has not moved for several days or a week. It is certainly not only safe but desirable to wait for at least a month and often as long as three months, always providing no symptoms occur suggesting threatening perforation. In the Chevalier Jackson Clinic in Philadelphia, where they are used to dealing with many of these cases, they always wait one month before advising operation. I remember a mother who was told after this time that her baby who had swallowed a safety-pin should now be operated upon, refusing; two months later she came up triumphant with the open safety-pin. Even if you operate on these cases it may be most difficult or impossible to find or extract the object. I watched one little girl with a Kirby grip in the duodenum for four months and then did a laparotomy at the request of the parents. At operation I felt the grip once and then lost it and a long search proved fruitless. Thirty-six hours later the grip was safely passed per rectum. In spite of our fears to the contrary, perforation of the bowel by a foreign body is a very rare occurrence and, in many of the cases in which it does occur, it is when there is no knowledge of the foreign body having been swallowed. This was so in the two cases which I mentioned earlier. I was fortunate enough to operate on these two within three months when I was a surgical registrar. I went through the records of this hospital for some forty years back and could find no other single case, and enquiry from several surgeons revealed only one other in their experience. I also studied much of the literature on the subject, and soon found that perforation by a foreign body known to be swallowed is also a recorded rarity. In many of the recorded cases perforation has taken place quietly; the passage of the object, usually a pin, has been protected by omentum and it has often been spontaneously extruded from an abscess in the anterior abdominal wall to the surprise of everyone. You may re-assure yourselves, therefore, and your patients, as to the dangers of perforation by a foreign body providing always a proper watch is kept for threatening signs or symptoms.

In the two cases just mentioned perforation occurred soon after a dose of salts had been taken; no doubt the hurried, irritated action of the bowel was the cause of the disaster. This should be a warning against allowing or advising an aperient when consulted about a swallowed foreign body. An anxious mother is very liable to want to shorten her waiting time by giving a smart purge. An ordinary diet should be given with no alteration unless it is an increase in roughage forming vegetables. I doubt if the popular suet-pudding diet is of much use in protecting the foreign body. If the object is sharp or pointed it may be a good plan to give many *tiny* pledgets of cotton-wool at intervals; these may catch up on the foreign body and guard its passage.

Sector News

Guy's Letter

ALMOST successful Christmas will be long remembered by everyone in the Hospital this year. Decorations in the wards were better than ever, in most cases home-made and therefore more original. The long succession of parties was started on Christmas Eve with a dressers' tea, after which carol-singers went round the wards. All then adjourned for an excellent impromptu dance in the theatre-nurses' sitting-room.

On Christmas Day the patients were delighted to have turkey for dinner, some of them for the first time. During the afternoon the Out-patients' Hall was once again the exciting scene of a Landon tea, this time on a minor scale unfortunately. Instead of the usual six hundred Borough children attending, one hundred came at two o'clock and shouted themselves hoarse to the accompaniment of a band. They recited, sang solos and played on the drums for prizes, and then sat down to an enormous tea. Before they left at 4.30 p.m. each child was presented with a gift from Father Christmas, who was patronisingly hailed with " Hi, mister ! I want that one ! "

That evening nurses, staff and students gathered in the Nurses' Home for an excellent Christmas dinner. Speeches were made by the Matron and Superintendent. Dr. Bishop paid a tribute to the kitchen staff for doggedly sticking to their posts during the upheaval of the " blitzes " to feed the hungry at all hours.

Boxing Day, too, was crammed full of festivities. In the wards there was community singing; a Punch and Judy in Addison; while in Mary, Edward Cooper came from the Savoy to amuse nurses, students and patients with a suitable entertainment.

To end the holiday the Matron and Nursing Staff held dances in the new Nuffield Nurses' Home on December 28th and 29th. Both of these were great successes and exceptionally well attended. Big occasions, too, were the charwomen's tea-party, reminiscent of Walt Disney's " Dance of the Hours " in " Fantasia," and a dance held by the Guy's Social Club. T. L.

Farnborough Letter

IN the last issue of the *Gazette* you were promised an account of the revelry at Christmas. Unreported is a dance on December 8th, 1942. It was the usual success. Up to Christmas there was a multitude of Brain Trust and Socialist talk, which indubitably must be set on record but cannot be reported on. As Christmas got nearer tea was increasingly easy to get on the wards (inversely proportional to the square of the number of days to Christmas).

On the 25th a bran tub enlivened a party in the Maternity Block. Suffice it to be said that a certain dignitary thought herself to be a duck and the bran-tub to be a pond ; order was restored when the bran was shaken from the duck ! Dances were held in Mary and Edward. Bufs tells me that there was a cabaret show in Mary !

On Boxing evening the maids' dinner and dance was held. One of the high spots of the evening was when an eminent member bagged the jitterbug prize. Bufs also tells me—but enough ! Two days later was the night nurses' and juniors' dance. This was good fun, but not quite such a riot as the previous one. The 28th brought us to the day nurses' dance, preceded by a dinner. It is not the dinner that I am going to report nor the dance (beyond saying that it was another big show) ; it is the happenings afterwards. Bufs, ignoring his favourite tree, set forth for a party. He was just slinking along near the Nurses' Home, when extraordinary things happened. There was a searching beam accompanied by an ogre voice proclaiming to him, and other revellers, that they had " better go in now." He remembered similar occasions at Pembury two years ago and at Guy's last Christmas. Bufs sighed : " The Hospital Gestapo again ! " It would not cook his goose, he thought, and crept away under the cloake of darkness. Work proceeds as usual. P. L. B.

Correspondence

ADMISSION OF WOMEN STUDENTS.

To the Editor of the GAZETTE.

SIR,—We must all be grateful to Mr. Morgan for his letter in your issue of December 26th, 1942. He has put forward for the first time a new view. He does not oppose women's medical education. He merely opposes co-education in the clinical period.

Mr. Morgan is in agreement " that women should have equal opportunities and the best possible facilities " with those of us who think we ought to take women at Guy's. I agree that this was not debated. It never has been at any meeting at Guy's where the matter has been raised.

Mr. Morgan seems to disagree with me on two points. He says that the one part of university education in which co-education should not exist is the teaching of clinical medicine. I say that as these young men and women have to work together the moment they get qualified ; co-education is more needed in this than in any other form of undergraduate training. Alternately he says that we should adopt to clinical medicine in the University of London the methods used at Oxford and Cambridge for the preclinical studies. I say that while we must absorb from the older universities that which is good in them, we must not attempt to copy in a young university situated in the vast capital of a great empire methods that have evolved in small country towns out of the relics of the monastic system. I first heard this enunciated by a great Oxford man, Sir William Beveridge, when he was vice-chancellor of the University of London. But as Mr. Morgan is in agreement with the moral principle that I tried

to get enunciated at the school meeting, there should be room for compromise in these details in carrying out our responsibility for putting into effect that principle. Whatever may happen in the future we are faced with the responsibility for the education of a large number of girls who have already spent three years of their young lives studying medicine. Two hundred and fifty applied for the ten vacancies allowed by one of the London schools. You cannot make new schools arise by the stroke of a magician's wand. What does Mr. Morgan propose to do ? Will he hand one of the existing schools over to women's education and distribute the men among the remaining medical schools ? And, if so, which one ? Would St. Bartholomew's agree to his handing them over to the women ? And, if not Bart.'s, which other school can he ask to be taken over ? Except his own ? Well, if he can do nothing except hand over Guy's I am prepared to face the sacrifice. But I think it would be wrong and unnecessary.

Let us follow up his second suggestion. Supposing all these girls were attached to the Royal Free school and facilities were organised for them by combined rounds and other means at the other schools. Is he prepared to accept one visitor from the Royal Free to every four of his men students ? I am if he can manage no other way, but I should think it bad administration on his part. I think we have to recognise our responsibilities to these girls and take them as students, and that the school council should arrange for 20 per cent. of all new entries from October next to be women, and should announce it to the world before the end of this session ! Look to Guy's to lead. If we do I believe all the other schools, except one or two, will follow. The time has come to cease saying we will take women students when all the other schools do. Agreement will not come that way.

One branch only of medical work has up till now been entirely in our hands—and that is education. Upon what we do with that will largely depend how much confidence is put in our advice that is given in other medical matters. If we try to carry out medical education in narrow, sectarian, selfish, traditional ways we shall be weighed in the balance and found wanting. If we do it on wide lines in the interest of " the People and their Needs " our word will be trusted in other matters. And so I believe that the future of our Hospital and our School largely depends upon how Mr. Morgan and those that hold, with him, the reins of power carry out " the principle that no difficulty of ways and means should affect the provision of the best facilities for medical training of women students."

Yours, etc.,

T. B. LAYTON.

To the Editor of the GAZETTE.

SIR,—Although I am opposed to his attitude on the question of the admission of women students to all teaching hospitals, I could wish that your correspondent, G. M. Turner, had been a little more fair and accurate in his facts. Among musicians and artists perhaps the names of Dame Ethel Smyth and Dame Laura Knight are not altogether unknown ; but, surely, Mr. Turner should be aware that the supremely great Madame Marie Curie—Nobel Laureate in Physics and in Chemistry—never aspired to qualification in medicine, although she did receive honorary doctorates in that subject from certain universities.

Yours, etc.,

Chemistry Department,
Guy's Hospital Medical School, London, S.E.1. CHARLES S. GIBSON.

To the Editor of the GAZETTE.

SIR,—The arguments against admitting women students to Guy's are poor, as indeed they must be of necessity, there being no case to argue. What other hospitals have done Guy's can do. No, sir, it is purely a matter of prejudice, but women *will* be admitted to Guy's one day. No one can stop the wheels of Progress altogether. Time marches on, but the clocks at Guy's may need just a little more oiling.

Yours, etc.,

1, Harley Street, W.1. W. ARCHER HODGSON.

POST-WAR NURSING.

To the Editor of the GAZETTE.

SIR,—With regard to your correspondence concerning "Post-War Nursing" and "*Reconstruction of Nursing*" I should like to add a few comments.

Firstly, lest any readers of the *Gazette* have the impression that it was intended to indicate that these topics were felt to be disregarded or lightly passed over by those in authority at Guy's I should like to say that such an opinion was far from my thoughts. I made reference to nurses only, and am not unaware that Miss McManus is President of the Royal College of Nursing, or that Sister Florence Taylor is the Chairman of the Sister Tutors' Section of the Royal College of Nursing; nor, indeed, would I doubt for a moment that they and others are, indeed, the able hands referred to in correspondence in your last issue.

Secondly, I should like to say that any reasonable person will readily see that results are best achieved by corporate action through "our organisations." Much work, one knows, is in progress, and one recognises the fact that quick results on a wide scale are not expected, especially during these times, or, indeed, even desirable, lest undue impatience should in the end prove detrimental to our purposes.

No, my observations I would confine to a rather different aspect, as originally intended, and that is to the subject of general stimulation and propaganda.

As truly recognised in this country, and indeed everywhere, one of the most powerful weapons for the furtherance of any cause is propaganda. It is in this respect, both amongst ourselves and on a wider scale, we perhaps lack vigour. Granted the nursing press deals with the topics in question, granted the nurses have access to the press and that many of them are regular readers, but activity seems to halt here and discussion tends to become undirected. It seems to me that in this field some organisation might prove helpful "to those who feel strongly on the subject" and an inspiration to those who heretofore have concerned themselves rather less with the matter.

I would like to suggest that your correspondents from Orpington and I have much in common with regard to reconstruction, for they, too, advocate "thought and discussion in the Hospital." My original correspondence sought to ascertain how deep was the student nurses' interest in current nursing matters (this point has undoubtedly been proved at least in one base) and was backed in my own mind by the hope that we might see our way to correlate our activity and give more concrete expression to our opinions, thus enabling the effects of the work that is being done by others to be felt more personally amongst us.

Yours, etc.,

Guy's Hospital, S.E.1. F. S. BECK.

LETTER FROM GERMANY.

We have received the following letter that was sent to the president of the Rugby Football Club:—

SIR,—I am writing at the instigation of the President of the Stalag Luft 3 Rugby Club. Shortly after our arrival at the camp last May, the above club was formed and it was decided to start a "League," comprised of teams from the various barracks. Consequently each barrack was named after representative teams in England, this barrack being known as "Guy's Hospital." It is, therefore, as the "Guy's Hospital" representative that I write.

The series of games which have taken place up to date prove that Rugby in this camp has a very good following and the standard and spirit of the games has been very high. Unfortunately, we find that much of the attraction and pleasure is missing due to lack of equipment.

I have, therefore, to inquire if you can help us in this matter of kit by sending us whatever you possibly can in the way of jerseys, shorts, stockings and boots. I trust, therefore, that you will give the matter your full consideration. Thanking you in anticipation.

Yours, etc.,

C. DAVIES (for Camp Leader).

P.S.—As a matter of interest, "Guy's" has just won the Camp "League Championship."

Reviews

Handbook of Physiology and Biochemistry. By W. D. HALLIBURTON and R. J. S. MCDOWALL. 37th Edition. Published by John Murray, 1942. Pp. 977. *Price* 21*s.*

THIS edition does not differ considerably from the previous one, all the features, both good and bad, being retained. The book still contains more than a hundred sheets of blank paper, for the purpose of writing notes. It seems to the reviewer that such a misuse of paper is disgraceful in these days of paper shortage.

The book covers the syllabus for the various examinations in physiology and is easy to read and understand. Although it is well suited to the requirements of Conjoint students, it is not sufficiently full for B.Sc. students, especially in the biochemical sections. Nevertheless, students starting their physiological studies would profit by a reading of this book before passing on to more detailed text-books. M. L.

Medical Jurisprudence and Toxicology. By JOHN GLAISTER, M.D., D.Sc., Regius Professor of Forensic Medicine, University of Glasgow. 7th Edition. Published by E. & S. Livingstone. Pp. 671. *Price* 28*s.*

CONSIDERING the relatively small amount of study the student can give to forensic medicine he is surfeited with sound text-books. Sidney Smith and Glaister are family traditions with which to conjure, and Kerr has quickly—and justly—won respect for its clean attractiveness. The field is a keen one, and here is a seventh edition of Glaister, the second to fall to the present author. The first was a disappointment to many—"guarded," "conditional" and "a little pedantic" to quote a contemporary critic, with seriously out-of-date references and illustrations, the majority of which fell naturally into categories C and 4.

Glaister has now clipped his handicaps in the field by a masterly re-writing, re-editing, type-heading, weeding of references and illustrations. The new book, whatever its little personalities of text, is an authoritative modern text-book which alone would establish English—or should it be Scottish—medical jurisprudence in the front rank.

It is a remarkable source of detailed information, accurate to the *n*th degree unless one seeks to split Lilliputian forensic hairs with the author, or to judge the text by Fowler standards. As we review it for the student this would be raising issues of comparative unimportance and we shall not comb the text.

Suffice that this is an authoritative text-book of a kind the student will keep after he qualifies; he will never refer to it in vain. Shall we admit in the same breath that all but the prizeman will quail before the vast quota of information Glaister has contrived to include within these 650 pages? In fairness we must. This is a volume, not a pocket-book; a compendium rather than an outline. It is "all or nothing"; the student will not find forensic medicine an easy engaging task with this as his bible; but he will, if he masters it, master his examiner also. C. K. S.

Pye's Surgical Handicraft. Edited by HAMILTON BAILEY, F.R.C.S. 13th Edition. Published by John Wright & Sons. *Price* 25*s.*

THIS really is a remarkably valuable book on good house-surgeonship, and I thoroughly advise anyone recently qualified to buy it. It will save him from making a large number of mistakes, and from asking a large number of questions, and it may well surprise him to learn how much he can contribute to the success of his surgeon, and likewise how much responsibility he must take for his surgeon's failure.

The book is written by a variety of authors, and amongst the pundits who have their fingers in the pie are Gabriel on the rectum and anus, Holmes Sellors on the chest, Watson Jones on fractures, Norman White on gynæcological procedures, and Evelyn Pearce on the administration of enemata.

The information is of two varieties. The first might be called "The House Surgeon in the Wards," and it is for this that the book is so immensely valuable; and the second might be called "The Young Surgeon in the Operating Theatre"—that is to

say, it deals with the minor operations of surgery which might be given to the house surgeon. One is not in a position to criticise the latter, coming as it does from the gods; and the former is so good that there is little scope for criticism.

There are one or two points, however, which deserve mention. The chapter on "Urine" is absolutely first class, and the fact that pus must never be said to be either present or absent without resort to the microscope is emphasised. This is probably the most useful chapter in the book. Intravenous therapy and fluid balance is discussed thoroughly, and this is for the most part good, but the preferences for saline over glucose, and even a hankering after glucose-saline, are difficult to understand. There is no mention of the qualitative estimation of the chloride content of the urine as a method of deciding how much chloride to give in the continuous drip. This is certainly the easiest, quickest and a very reliable way.

In the chapters on pre- and post-operative care rather a lot of space is given up to consideration of the heart, compared to the space given to the chest, and, when the latter is considered, much time is spent on the diseases of the lung tissue, whereas the mobility of the thoracic cage is dealt with all too briefly.

The suitability of the various veins for continuous intravenous therapy is well treated, but I would suggest that if the vein on the radial border of the forearm, just above the wrist is used, there is no necessity to splint the arm, and the patient may use it for holding his book and feeding himself.

But let there be no doubt, these criticisms are merely on points of technique, and if any house surgeon were to know all that this book has to tell him he would be one in a million. H. A. R.

Tropical and Sub-Tropical Diseases. Oxford War Manuals. By C. H. BARBER, D.S.O., M.A., D.M., M.R.C.S., L.R.C.P. Published by Oxford University Press. London: Humphrey Milford, 1942. Pp. 189. *Price* 5*s.*

THIS little manual, written almost in note form, gives a brief clinical picture of the main "tropical" diseases. It would be difficult to grasp the subjects without some previous knowledge, and the entomology, parasitology and laboratory work are only briefly mentioned and illustrated with a few diagrams. These subjects are so important in the prevention and diagnosis of tropical diseases that further detail is essential. For all doctors going abroad with the Services who have done a course of tropical medicine, this book will be an excellent reminder, from the clinical viewpoint, of all they have had to learn in so short a time. Its size will be found a great advantage, as it can be put in the pocket. E. B. F.

A Pocket Medicine. By DR. G. E. BEAUMONT. Published by J. and A. Churchill. *Price* 10*s.* 6*d.*

IT is very doubtful whether short books like this should be recommended to students. It certainly cannot serve as an introduction to medicine as the author claims in his preface, though it has its merits as it is easily carried about and can quickly be read in last-minute revision. Dogmatism naturally must be forgiven, as it cannot be avoided with the limited space available. Insufficient prominence is given to important causes of symptoms and junior students may feel after reading the chapter on hæmatemesis that this manifestation is just as commonly caused by gastric crises as by gastric ulcers.

The list of diseases discussed is most comprehensive, but it might have been more profitable to add the space given to conditions as Mikulicz's disease, dermatomyositis, ochronosis and leukanæmia (incidentally, hæmatologists do not seem to believe in this disease) to the discussion of other more common conditions.

The reader is rather surprised by a considerable number of inaccuracies. Posterior basic meningitis is not a term equivalent to cerebrospinal fever occurring in infants. Paralysis agitans is not due to degeneration of the pyramidal motor system of the brain. Lower motor neurone lesions of the ophthalmic division of the fifth nerve cannot exist.

The sulphonamide group of drugs is, perhaps, given rather too indiscriminately. Sulphaguanidine has not been given sufficient trial in ulcerative colitis, whereas the value of sulphapyridine in measles and anterior poliomyelitis must be a rather doubtful one.

Syphilis is not as important a cause of angina pectoris these days as this book might suggest and air replacement is not an obligatory sequel to aspiration of pleural effusions.

The chapter on nephritis is most disappointing. Each text-book of medicine and pathology has its own classification and the more different books the student consults on this matter the more bewildered he is. W. G. T.

Sport

Rugby

GUY'S *v.* ALDERSHOT SERVICES.

(At Aldershot on Saturday, November 28th.)

With Mullins away captaining London, and Lee and Strathie playing in the same game against A.A. Command, Guy's turned out a much weakened side on the Aldershot Command ground. Other absentees were Lewis and Willcock, and C. H. Kinder from Sherborne and Cambridge came into the side as hooker.

Aldershot had a poor side and should have been beaten by a bigger score. The play was very scrappy, especially in the first half, but Guy's could not press home their territorial advantage, but Brangwin carved out a beautiful opening which enabled A. C. Macrae-Gibson to score a fine try.

The team settled down nicely during the second half and overran their opponents. Edwards made an excellent run down the wing for a try, which was followed by a grand cut through by A. C. Macrae-Gibson, and Batty-Shaw was up to take his pass for an unconverted try.

Wilshere played a captain's part by scoring a try and kicking two penalty goals.. The players had much amusement from the attempts to convert, and as none were successful, the kicking speaks for itself. One effort was a perfect daisy-cutter all along the ground. Edwards was tackled right on the line after intercepting a pass in his own " 25," and was out by himeself until a pursuer eventually caught him. Taken on the whole it was a creditable performance and Guy's reserves did very well indeed.

Score: Aldershot Services, nil; Guy's, 2 penalty goals. 4 tries (18 points).

Team.—E. K. Harris; D. R. Edwards, P. L. Brangwin, A. C. Macrae-Gibson, J. N. Micklem; W. H. Lillywhite, R. N. H. Vann; B. H. Wilshere (captain), C. H. Kinder, R. G. L. Brittain, A. G. Albers, A. Batty Shaw, P. D. Harvey, C. Vidot S. M. Hilton.

GUY'S *v.* ROSSLYN PARK.

(At Old Deer Park on Saturday, December 5th.)

For the second week in succession Guy's were compelled to field a weak side. The United Hospitals, for their game against the Army, claimed Mullins as captain, and Strathie, Albers and Lee, but even so, Rosslyn Park were fortunate in piling up such a big score, and on the run of the play Guy's did not deserve such a licking.

The opening exchanges went in favour of Guy's, but N. A. Steele opened the score for the Park with a penalty goal, and following this success he proceeded to convert two tries by S. A. Evans.

Guy's three-quarters had a fair amount of the ball, but could do nothing with it; but the forwards played up magnificently, being very good in the loose, and Wilshere made an opening which sent Harvey over for an unconverted try.

The Park attacked the Guy's line and a dangerous dribble by Unwin led to Camp touching down, and again Steele converted. Guy's continued to fight back and, from a penalty award, Lewis took a " drop " which sailed over the bar, but the Park came again and Steele completed an excellent nap hand of kicks by converting a try by W. L. Taylor. A. C. Macrae-Gibson, on the wing, held a firm grip on Sutherland, the New Zealand star three-quarter, but the Guy's backs were woefully weak in attack.

Score: Rosslyn Park, 4 goals, 1 penalty goal (23 points); Guy's, 1 penalty goal and a try (6 points).

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, N. K. Macrae-Gibson, P. L. Brangwin, J. N. Micklem; W. H. Lillywhite, R. D. Willcock; B. H. Wilshere (captain), C. H. Kinder, R. G. L. Brittain, I. H. Hilliam, A. Batty-Shaw, P. D. Harvey, C. Vidot, S. M. Hilton.

GUY'S *v.* BART.'S.

(At Honor Oak Park on Saturday, December 12th.)

Keen tackling kept the score down in this game. C. Vidot had one of his very best days, his play was of a high standard, and Lillywhite varied his game with well-judged cross-kicks and sound defensive kicking. Strathie showed signs of a return to form and produced several of those bursts which spell danger to any opposition.

Guy's had much the better of the first half, but all their score came early in the game. Lillywhite brought off an accurate cross-kick, which Strathie gathered to send A. C. Macrae-Gibson in for a try. The second score was similar; Lillywhite passed to A. C. Macrae-Gibson, who cross-kicked for his brother, N. K. Macrae-Gibson, to touch down, and Mullins converted.

Lewis went close with a drop-kick, and a forward pass stopped Bart.'s as Hall broke away. Livingstone, the Bart.'s full-back, saved his side on several occasions with good handling and kicking, and once prevented A. C. Macrae-Gibson from crossing when close to the line. Bart.'s forwards took play to Guy's " 25 " and, from a reasonable position, Hawkes missed a penalty kick.

The second half opened with Guy's attacking and Strathie took advantage of an excellent three-quarter movement to make an opening for Micklem, but the latter was overhauled and tackled by Davey. Strathie constantly cut through and made some clever runs, but Bart.'s forwards always recovered to prevent a score.

Gibson, the Bart.'s centre, was twice stopped by Lillywhite with neat ankle tackles, but Bart.'s reduced the score with a penalty goal kicked by Gibson.

Considering that Guy's had so much of the ball it was surprising that the excellence of the backs did not produce better results, but the answer is, Bart.'s forwards never allowed their opponents more than a few yards to manœuvre.

Score: Guy's, 1 goal and a try (8 points); Bart.'s, 1 penalty goal (3 points).

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. D. Willcock; E. H. Couper, A. B. Lee, R. G. L. Brittain, A. Albers, A. Batty-Shaw, P. D. Harvey, C. Vidot, M. R. Mullins.

GUY'S *v.* ROYAL NAVAL ENGINEERING COLLEGE (DEVONPORT).

(At Honor Oak Park on Saturday, December 19th.)

The R.N.E.C. (Devonport) came to London with an unbeaten record this season, and fielded a side containing three war-time internationals, and ten, who had played for the Royal Navy against the R.A.F.

Guy's fielded their best XV for some weeks, the only absentees being Lewis and Brittain, but so well did Brangwin perform that the last line of defence was as firm as a rock, and

Kinder played very well in the front row of the pack.

Early on the College attacked with short, accurate passes and it was evident that speed and the inside pass was their strong point. They had an early shock when A. C. Macrae-Gibson caught the ball, just outside his own "25," from a punt by the opposing full-back, and dashed for the line in the style of a seasoned sprinter. Mullin's kick hit the cross-bar and came back the wrong side.

The passing of both sets of backs was delightful, and the forwards were called upon to relieve some dangerous movements.

The second half was superb. Guy's three-quarter line worked better than at any time this season. Cunningham, the College scrum-half broke away in the first minute, and a scrum on Guy's line was repulsed. An excellent bout of passing between N. K. Macrae-Gibson and Strathie, enabled the latter to open out for Micklem to send Harvey in for a try. Simmonds went very close with a drop-kick for the College, but later made an excellent run and punted ahead for Sylvester to score an unconverted try.

Guy's forwards made some skilful dribbles, and broke up the many fast-moving attacks of the College outsides. Strathie came right back into his very best form, and combining well with his backs, cleverly drew the opposing defence for Micklem to cross the line for Mullins to convert from the touchline.

All round it was a delightful exhibition of football. The forwards had a grand battle in the loose, and the deadly tackling closed the gap down the middle which the College attack constantly exploited.

Score: Guy's, 1 goal and 2 tries (11 points); R.N.E.C. (Devonport), 1 try (3 points).

Team.—P. L. Brangwin; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. D. Willcock; B. H. Wilshere, C. H. Kinder, A. B. Lee, A. G. Albers, A. Batty-Shaw, P. D. Harvey, C. Vidot, M. R. Mullins.

Hospital Information, etc.

Pass List

CORRECTION

F.R.C.S. EXAMINATION.

It is much regretted that, owing to an unfortunate error, the Editors were informed that the results of the Fellowship examination, published in the last issue of the *Gazette*, were the final, but it now transpires that the examination was the Preliminary. Therefore the correct wording should read:—

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

November, 1942.

N. Gillman S. Muntarbhorn

EXAMINING BOARD IN ENGLAND.

FIRST EXAMINATION.

December, 1942.

Anatomy.

A. G. Atkinson W. M. C. Hallinan
D. G. Breeze H. W. Topham
W. W. Cree

Physiology.

D. G. Breeze H. A. R. Loxdale
A. C. Campbell H. W. Topham
W. W. Cree

UNIVERSITY OF LONDON.

EXAMINERS IN SUBJECTS OF EXAMINATIONS FOR MEDICAL DEGREES FOR 1943.

The following Guy's men have been appointed Staff Examiners:—

Applied Pharmacology.—N. Mutch, M.D.

Chemistry.—Prof. C. S. Gibson, O.B.E., Sc.D., F.R.S.

Physiology.—Prof. C. S. Gibson, O.B.E., Sc.D., F.R.S.

Surgery.—Associate Examiner N. L. B. V. Eckhoff, M.S., F.R.C.S.

First Examination for Medical Degrees.

Inorganic Chemistry.—External Staff Examiner *C. S. Gibson.

General Biology.—T. J. Evans, M.A.

Physics.—G. Stead, M.A.

Second Examination for Medical Degrees.

Anatomy.—J. Whillis, M.S.

Physiology.—*W. R. Spurrell, M.S.

Second and Third Examinations in Dental Surgery.

Physiology.—W. R. Spurrell.

Prosthetic Dentistry (including Metallurgy).—*H. R. B. Fenn.

Special Anatomy, Special Physiology and Dental Histology.—*H. L. Messenger.

Pathology and Bacteriology.—H. Bulleid.

Pharmacology.—*K. Hooper.

Dental Surgery and Operative Dental Surgery.—W. E. Herbert.

* Marked with an asterisk have been appointed Chairmen of their respective Boards.

Awards

O.B.E.

Miss Dorothy M. Smith, Matron, The Middlesex Hospital; Guy's, 1916–29.

Prisoner of War

Captain C. S. Pitt, R.A.M.C., previously reported missing.

Missing

PECK.—Missing at sea, October, 1942, Captain Charles Wm. Peck, R.A.M.C. Any information gratefully received by his mother, Mrs. F. G. Peck, Post Office, West Ilsley, near Newbury, Berks.

Birth

MUKERJI.—On November 14th, 1942, at Guy's Hospital, to Hilda Mary (née Dore), the wife of Hiren C. Mukerji, M.Sc.—a son (Nichola Guy Roy).

EDS. { H.B.F.O. P.F.E.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVII. No. 1422 *23rd January, 1943* *Ninepence*

PASSIM

IT was shown in a ballot that was held at Guy's on the admission of women students that the majority were opposed to the suggestion that women should be admitted on either a temporary or permanent basis. Now this appears to be rather strange since the students who voted on this occasion are unlikely to be affected by this proposed innovation during their student careers, so it would appear as if the reason for their opposition was not the dislike of being taught with women. We must, therefore, seek the reason elsewhere—assuming that there is a reason and that it was not opposed in a perverse spirit of reaction. Can it be that they thought that there was no room and no need for more women practitioners ? This point has been dealt with by one of our recent correspondents, and it is obvious that if we are to have a comprehensive health service we shall need many more practitioners and a great number of them will have to be women. Before the War there was one woman for every ten men practising medicine, and it seems likely that there will not only be an actual increase of women in the professions, but the proportion of women to men will increase as well. Can it be that they thought that women are naturally inferior to men and not suited for such tasks ? The answer to that is that when women have been given the same opportunities they have shown themselves to be quite as competent. It is quite true that there have been many more really great men than women, but as there is only about one genius to each generation it seems rather absurd to make comparison on that score and follow it up by saying that women are, therefore, inferior. It is probable, however, that these and other reasons like them are but the rationalised arguments that are designed to cover the objection, which a certain group of men have, to admitting that women are their intellectual peers. This might explain the inconsistency that exists in war-time when we have women doing a number of jobs—and doing them well—which were said to be unsuitable for them in peace-time. The question as to why they should not be educated apart, if they must be educated at all, has been quite adequately answered by Mr. Layton in his last letter. This is a time of change and if we wish to avoid the fate of the dodo we must conform our opinions to the realities of our environment.

In concluding this topic, we thank all those who have been kind enough to write, and regret that the paper restriction does not permit us to publish every letter that has been received.

IN the last issue we published a letter from Germany which was written by a prisoner-of-war. In the letter he was appealing for games equipment so that they might be able to play Rugby football with more enjoyment than they do at present, since they are now handicapped by the lack of kit. They have honoured our hospital and the Rugger players especially by naming one of their teams " Guy's." ; so it is only right that we should support this team in every possible way. The Red Cross tell us that we can send equipment over there and we are sure that there are a number of students at the Hospital who no longer have any use for their Rugger kit and would be only too pleased to see it put to this useful purpose. We, therefore, propose that all those who have serviceable jerseys, shorts, stockings and boots should send them to the *Gazette* Office, addressed to the Editor, and we shall arrange to dispatch them to the Red Cross, who will send them on when there is a sufficient quantity. Please send us everything you can spare.

WE congratulate a student nurse of Guy's, Miss Audrey Pope, on winning the first prize for an essay, which she has written for the *Nursing Times*. The subject of her essay was " Gastrectomy and Duodenectomy followed by Collapse of Part of the Lung."

WE would remind our readers that the annual subscription to the *Gazette* and " Directory of Guy's Men (Medical and Dental)," 12*s*. 6*d*. per annum, post free, is now due, and to avoid the additional cost of postage and to save paper it would be appre-

ciated if they would kindly forward the same to the Manager, the *Gazette* Office, Guy's Hospital, S.E.1.

THE other day we heard that nurses are being given instruction that appears more fitted to land girls than to nurses—at least, it looked like that on first inspection ; but, on further perusal, it transpired that the misunderstanding was due to an incorrect use of the Hospital vernacular. It happened that a nurse was being asked what experience she had had in children's wards. " Oh," she said, " I did my lambing in the children's ward at Pembury ! "

WE are very pleased to learn that Dr. Ryle has been elected Professor of Social Medicine at Oxford University, so adding to his achievements and conferring honour on the Hospital.

AS we are going to press we hear, with regret, of the death of Sir William Arbuthnot Lane. A memorial service was held at the Chapel, Guy's Hospital, on last Thursday. We hope to be able to publish an obituary in the next issue.

The Nurse as Citizen

THIS was the title of a talk given by Miss MacManus to Guy's nurses at Pembury last month. It was a pity that it was addressed to so few members of the profession. Few people realise more keenly than Miss MacManus the changes that loom ahead in the nursing world and how slow and unprepared the average nurse is to dictate for herself the nature of these changes.

She stressed the importance of being alive and aware of the world outside the Hospital grounds. It was obvious, she said, that the trained nurse and the student nurse had little or no time for active work outside her own, but that should not prevent her from being interested in the reforms for common good and to use her vote intelligently to this end. With this end in view, to read the daily Press, and not only the paper that expressed ones' own policy, others that expressed opposite policies. To use the public libraries ; to read and read ; to hear about public bodies ; to go abroad during holidays ; to be interested in the many aspects of life ; and to realise the contribution made to Society by other professions and trades. Above all, to learn about the profession of her choice—not merely a question of accruing knowledge to pass examinations, but of absorbing knowledge, soaking it up from the wide sphere of practical experience, both from her own and from those placed in authority over her. To be an active member of professional organisations, particularly the College of Nursing.

No reason, Miss MacManus said, why a nurse should not be a Member of Parliament —to stand, not as a nurse, but as a good citizen and, when matters relating to nursing were under discussion, a specialist's opinion could be given. To make such a contribution there is much preparation and it is only the very few who are called upon, but for the many there are countless small ways—both inside hospital and out. Self-discipline making for law and order ; consideration for others. Do not say, " This is nothing to do with me " when a field gate is left open and cattle are straying across the road. It is to do with each one of us—a personal concern as a good citizen.

In conclusion, Miss MacManus gave us the aim of a good citizen—" the well-being of the community ! " What a note it should strike in the minds of those who listened. If we do not arouse ourselves from this somnambulist state we shall have snatched from us the privilege, the liberty of being concerned with the well-being of the community ; we shall awaken too late to check the onsweep of State control. And what does this mean. Totalitarianism ; the line of least resistance ; the loss of liberty where a good citizen counts for nothing and the State counts for more and more.

What do we promise to the Italians and the Germans ? Freedom and liberty. Freedom from the total State, from the State that has become too prominent, that has not been kept in its place ; a totalitarian State ; the front in which they have lost their liberty. How unreasonable, then, to fight with such a cause when right in our midst, hammering at the doors is the scourge of State control. Shall we sit back and raise not a finger in protest against this wave of totalitarianism which is sweeping the nation that threatens our liberty, that chokes and strangles good citizenship.

How urgent it is at this time for us all to be concerned for the well-being of the community and of the nursing profession.

We regret that, owing to the lack of space, we have not been able to publish the above before.

Syphilitic Affections of the Eye

A Lecture delivered at Guy's Hospital Medical School on Monday, 30th November, 1942, by Frank W. Law, M.D., F.R.C.S., Ophthalmic Surgeon to Guy's Hospital.

GENTLEMAN,—I thought that perhaps it might interest you to consider the affections of the eye of a syphilitic nature as a whole. One is always coming across them in the Department and elsewhere, and it is interesting to get them correlated. Lectures, of course, should never take the place of a text-book, so I shall not keep you very long and shall touch only on those things which are of clinical interest and probably outside text-book reading.

Primary syphilitic affections of the eye are rare. I have been trying to think whether I have ever seen a primary chancre of the lid or conjunctiva, and I do not think I ever have. They certainly do appear, and their common site is inside the lower eyelid or outside on the skin surface of the lower eyelid; or in the lacrymal sac, for some obscure reason. One I can remember was reported by Foster Moore, in which he concluded that the lesion had occurred without any breach of surface at all. The intact skin had transmitted the virus and caused a syphilitic dacryocystitis. It was as hard as a stone and defeated diagnosis for some time.

The primary lesion on the lid is not typical in appearance, but is usually diagnosed by exclusion and by its response to treatment.

To turn to congenital manifestations of syphilis, I think that without doubt one of the commonest is the interesting and ever-present one of interstitial keratitis, or "I.K.", which is of considerable importance. Interstitial keratitis, let me begin by saying, is probably not essentially or primarily a keratitis in itself; it is more likely that it is an anterior uveitis with secondary involvement of the cornea, a state of affairs not by any means unknown in other conditions, and for which there is ample anatomical and embryological justification and explanation. Why does one say this? Because so frequently after "I.K." has settled down one can see the healed scars of the syphilitic lesion of the uveal tract.

There is no doubt that "I.K." is commoner in the female sex. I have some figures to which I shall refer constantly, quoting a paper entitled "Syphilitic Diseases of the Eye," written by Dr. S. H. Browning, bacteriologist to Moorfields Eye Hospital*. Out of 463 cases of "I.K.", 276, or 60 per cent., were in females, and those figures are borne out by other people's observations.

As for age incidence, the common time for the occurrence of "I.K." is in the 'teens. In females in Browning's cases the greatest number occurred at the age of seventeen, though in males it was twenty-one. He gives quite an interesting chart of age incidence—the age of onset in male and in female and in both sexes together.

AGE INCIDENCE OF INTERSTITIAL KERATITIS.

Of 463 cases of interstitial keratitis, 276 were females and 187 males.

FEMALES.

1 year 0	12 years 6	23 years 13
2 years 1	13 ,, ... 9	24 ,, ... 5
3 ,, ... 2	14 ,, ... 14	25 ,, ... 10
4 ,, ... 2	15 ,, ... 16	26 ,, ... 6
5 ,, ... 8	16 ,, ... 11	27 ,, ... 6
6 ,, ... 12	17 ,, ... 18	28 ,, ... 6
7 ,, ... 7	18 ,, ... 9	29 ,, ... 3
8 ,, ... 10	19 ,, ... 12	30-35 ,, ... 7
9 ,, ... 10	20 ,, ... 14	35-40 ,, ... 10
10 ,, ... 9	21 ,, ... 15	40-45 ,, ... 1
11 ,, ... 7	22 ,, ... 12	45-50 ,, ... 4

* *British Journal of Venereal Diseases*, 1930.

MALES.

1 year 1	13 years 4	25 years 7
2 years 2	14 ,, ... 6	26 ,, ... 5
3 ,, ... 1	15 ,, ... 4	27 ,, ... 8
4 ,, ... 4	16 ,, ... 7	28 ,, ... 1
5 ,, ... 7	17 ,, ... 6	29 ,, ... 1
6 ,, ... 8	18 ,, ... 8	30-35 ,, ... 7
7 ,, ... 11	19 ,, ... 7	35-40 ,, ... 4
8 ,, ... 6	20 ,, ... 8	41-45 ,, ... 0
9 ,, ... 12	21 ,, ... 15	46-50 ,, ... 2
10 ,, ... 2	22 ,, ... 5	51-55 ,, ... 2
11 ,, ... 5	23 ,, ... 2	56-60 ,, ... 3
12 ,, ... 8	24 ,, ... 6	

The clinical appearances of "I.K." usually leave little doubt as to the diagnosis. I frequently send cases for treatment without bothering about serological examination. A relatively sudden onset of pain, haziness, and redness of one eye in a girl, the inflammation not being of the obvious nature of the corneal ulcer or the phlyctenular lesion, but a type of infiltrated keratitis with possible early vascularisation in the cornea, is almost of itself diagnostic.

It is remarkable how frequently one obtains a history of trauma with "I.K."; there is the predisposed tissue presumably nourished by—I nearly said infected fluids. I suppose that is not quite the right word, but the situation is already set for this condition, and a foreign body, a scratch, or an abrasion starts it off. It is a condition of very considerable medico-legal importance if a youth at work gets a foreign body in the eye and develops "I.K.", which keeps him off work for months and leaves his vision permanently impaired. A comparable state of affairs would be that of the workman who strains himself and causes a hernia. It would be arguable that the work did not cause the hernia by any means, but that the predisposition was there and that the strain was the last straw.

In the treatment of "I.K.", so far as the local treatment is concerned, no great difficulty presents itself. It is obvious that the eye must be encouraged to cure itself of an inflammatory lesion. The uveal tract is probably certainly affected, and therefore atropin is indicated, and rest, protection and heat are all measures which must be adopted.

As for the use of diathermy for ocular lesions, I have no doubt that short-wave diathermy is of great importance in the treatment of "I.K." In the early days when I was running the physiotherapeutic department at Moorfields I thought that as the lesion was a keratitis, if not primarily at least secondarily, the treatment which did good to other types of keratitis might benefit "I.K.", but I had no success with ultra-violet light in the local treatment of "I.K."; which leads me to add, what may sound rather unsatisfactory to you, that I am not at all convinced of the effect of anti-syphilitic treatment in the ultimate temporal and visual prognosis in the case of "I.K." Here I am not quoting a book or just saying what everybody knows, for there is a very considerable difference of opinion on this subject. All I can say is that I have not been convinced that the general treatment makes very much difference to the length of time for which the patient has to be treated in order to obtain the visual result.

Let me say at once that the usual visual result is a good one. With the paper I have already quoted a chart is given indicating the visual results obtained, after treatment, in the "better eye" as it is called. Dr. Browning sets out the results in the following categories: full vision, good vision, practical, fingers, perception of light, and nil. On the treated side 74 per cent. were left with full vision, presumably $\frac{6}{6}$, 12 per cent. with good vision, and 14 per cent. with practical. On the untreated side 38 per cent. are said to have full vision, 33 per cent. good vision, and 19 per cent. practical. If one adds up the full and the good and the practical the total figures are very little different as between the treated and the untreated, only some 6 or 8 per cent. It might admittedly be objected that this is statistically unfair and that greater significance lies in the difference between the treated and untreated cases as regards "Full Vision"—viz., 74 per cent. and 38 per cent. However, I always reckon on principle that if you have the good fortune to be presented with a piece of information about a young patient, that he has a positive Wassermann and congenital specific inflammation, the least one can do is to treat it, and I send all my cases for general anti-syphilitic treatment. Not infrequently the Wassermann remains positive however hard one treats the patient.

A very common question one is asked by females who know what the condition means is whether they should marry and have children. There is really not the slightest objection to a person with "I.K." producing children. Syphilis in the third generation is extremely rare, and as long as they have the sense to keep themselves under observation, especially during pregnancy, the results of reproduction as regards the mortality and health of the offspring are no different from what they are in any other section of the community. Dr. Browning says, "I always say: yes, they may marry, but they must come to report. I have now a large family of healthy babies, and I have yet to see one of them with signs of syphilis"—that is, amongst those patients who have acceded to his request to have treatment during pregnancy.

If you find a patient of fifty or sixty years of age who does not see quite as well as he might and you cannot get a nice sharp shadow when doing retinoscopy and cannot get, say, $\frac{8}{12}$, make a good examination with the loupe and you will not infrequently find a fine haze throughout the cornea with either a collection of deep vessels, very fine, or possibly what we call "ghosts"—that is to say, tracts which have been blood-vessels and which no longer carry blood. You can then say that the condition is one of old healed interstitial keratitis, which accounts for the diminution of visual acuity.

You will notice, I hope, that in describing the congenital syphilitic lesion I have not gone into the general appearances at all. The other manifestations of general syphilis which so often go with "I.K." are common knowledge to you, and we need not waste time over them.

One must mention—to turn to the next head—acquired interstitial keratitis, although I personally find it a very rare condition. Clinically it differs little, I believe, from the congenital variety, and is said to be more prominent in the secondary stage, although it is liable to arise any time after infection from four and a half months to twenty years.

Syphilitic iritis is very rare. In discussing this matter with Dr. Browning I think he said that he had not seen a case of syphilitic iritis for nine or ten years, which is a very long time at Moorfields. It rather irritates me to see an old gentleman of sixty-seven, who has a low-grade iritis and possibly a few "K.P.", sent up to the department for a Wassermann reaction. If it is negative it is just too bad, because obviously it is meant to be positive, and, if positive, it does not prove that his iritis is syphilitic. If you are prepared to say that his iritis is syphilitic are you to send him on to the department for his six months on and six months off? On the other hand, if it does occur within six months of infection it may prove to be a late secondary manifestation.

There is a form of syphilitic iritis which is not so rare and that is the late tertiary manifestation—a sort of gummatous iritis. There one finds nodules either at the margin or at the root of the iris, and there is justifiable reason for referring to them as syphilitic iritis.

Another manifestation of iritis due to syphilis which I have never seen is the congenital type in infants. However, it is said to be not so very rare, though, knowing what I do about syphilitic iritis, which is said to be fairly common, I take that with a grain of salt. I am inclined to think it is rarer than the books say it is.

Choroiditis, or inflammation of the more posterior part of the uveal tract, is a slightly more common state of affairs. Again, it would be true to say that syphilitic choroiditis is more commonly of the congenital type. One finds not infrequently isolated peripheral healed lesions of choroiditis due to syphilis, and they link up with the lesions already referred to as being possibly the fundamental basis of interstitial keratitis. That is, therefore, one form of syphilitic choroiditis. The other is frequently disseminated, in which either the central part of the fundus or the whole fundus is involved. The fundus may be a mass of healed lesions, atrophied choroid, exposed sclera, heaped-up pigment on the edges of the lesion, so typically and graphically portrayed in the coloured drawings in the books.

I was interested to see, in the earlier part of this year, the relatively rare occurrence—for me, at any rate—of an acute syphilitic neuro-retinitis. That is quite a definite lesion and is extremely destructive of vision. I saw this man, who was a sailor, about six or eight weeks after his infection, when he was complaining of some loss of vision in his left eye. He had optic neuritis (inflammatory swelling of the optic nerve head), the retina all round was œdematous and contained exudate, and in the macular zone, there was a large pre-retinal hæmorrhage—that is to say, hæmorrhage from the retinal vessels—which was lying on the anterior surface of the retuina, between it and the

posterior layer of the vitreous known as the hyaloid membrane, though it probably does not exist as a membrane. Just *en passant* he described the loss of vision of the left eye as being considerable all over, but he said that there was a queer-shaped, particularly black arch just above his fixation point—an inversion, so to speak, of the sub-hyaloid hæmorrhage.

Syphilitic retinitis, as apart from the choroidal lesion, comes in the primary or early secondary stage. There is later attenuation of the arteries and veins and secondary atrophy of the optic nerve, and very often the eye is virtually useless.

Optic neuritis, which might well be mistaken for a papillodema, is again met with commonly within a year of infection. And optic atrophy is the all too common result of syphilitic disease. I have already mentioned the secondary atrophies and I need not define them again; after an optic neuritis or a neuro-retinitis atrophy frequently supervenes. But, of course, we have the atrophy of tabes, the atrophy which occurs in the late tertiary parasyphilitic disease. It might also occur, though it would be rather difficult to diagnose—and possibly could be diagnosed only by exclusion—as an isolated manifestation of atrophy of the optic nerve without other syphilitic manifestion, but presumably there would be a positive Wassermann to back up one's presumptive diagnosis.

One is left with the oculo-motor nervous palsies. I looked up the proportion of these palsies or paralyses which are due to syphilis, and was surprised to find that the official figure is one-third or rather more. I should say that probably more were due to syphilis, but the rest are made up by including obvious traumatic and acute infectious conditions; one has also to reckon with the thrombotic and arterio-sclerotic lesions which commonly give rise to oculo-motor nerve palsies. The third nerve may be involved, the manifestation including ptosis, and also the sixth and fourth nerves, giving an easier diplopia picture to work out! Ocular nerve palsy may occur as an isolated parasyphilitic phenomenon, as the result of pressure, involvement, or encirclement from an orbital gumma. One of its commoner causes is basal syphilitic meningitis causing involvement of the nerves in their intra-cranial course, but probably the commonest ultimate cause of syphilitic oculo-nerve palsy is a degenerative nuclear lesion brought about by disturbance of vascular supply. As a result of the syphilitic affection of the vessels supplying the meninges and basal nuclei of the eye there is a diminution of proper nourishment to the nuclei with degenerative changes. The lesion in that case is a definite nuclear lesion and not a peripheral lesion, and it is then extremely unlikely that you will get an isolated peripheral nerve or extrinsic ocular muscle lesion.

I do not want you to imagine that what I have said is, or might be referred to as, anything like a complete survey of syphilitic affections of the eye, but I have emphasised some points which you might not appreciate if you were merely reading in a text-book. In any case, in a text-book you have usually to go through section after section in order to find out from each what lesions are due to any particular cause, and to have brought them all together in the course of a short lecture may be of some advantage.

Sayings and Quotations of Sir William Osler

Internal Medicine as a Vocation, New York Academy of Medicine, 1897.

To walk the wards of Guy's or St. Bartholomew's, to see the work at the St. Louis and at the Salpêtrière, to spend a few quiet months of study at one of the German university towns will store the young man's mind with priceless treasures. I assume that he has a mind. I am not heedless of the truth of the sharp taunt—

> "How much the fool that hath been sent to Rome,
> Exceeds the fool that hath been kept at home."

Nurse and Patient, Johns Hopkins Hospital, 1897.

Referring to the gradually accumulating surplus of women, and to the spinster of twenty-five. "Now, at that critical period a woman who has not to work for her living, who is without urgent domestic ties, is very apt to become a dangerous element unless her energies and emotions are diverted in a proper channel. One skilled in hearts can perhaps read in her face the old, old story; or she calls to mind that tender verse of "Sapho"—

"As the sweet-apple blushes on the end of the bough, the very end of the bough, which the gatherers overlooked, nay, overlooked not but could not reach."

British Medicine in Greater Britain, British Medical Association, Montreal, 1897.

"The love of science, the love of art, the love of freedom—vitally correlated to each other, and brought into organic union" were the essential attributes of the Greek genius (Butcher). While we cannot claim for the Anglo-Saxon race all of these distinctions it has in a high degree that one which in practical life is the most valuable, and which has been the most precious gift of the race to the world—the love of freedom—

"Of freedom in her regal seat
Of England."

It would carry me too far afield to discuss the differences between the native Briton and his children scattered so widely up and down the earth. In Canada, South Africa, Australia, and New Zealand, types of Anglo-Saxon race are developing which will differ as much from each other, and from the English, as the American does to-day from the original stock; but amid these differences can everywhere be seen those race-qualities which have made us what we are—"courage, national integrity, steady good sense, and energy in work."

* * * * * *

One other lesson of Sydenham's life needs careful conning. The English Hippocrates, as I said, broke with authority. His motto was—

"Thou Nature art my Goddess; to thy law
My services are bound."

Correspondence

ADMISSION OF WOMEN STUDENTS.

To the Editor of the GAZETTE.

SIR,—During the last war seven of the London medical schools opened their doors to women; five of them subsequently reversed their policy and became once more schools for men only. Why was this? I suggest that Mr. Layton would be spending his time more usefully in expounding to us the results of this full-scale experiment than in devising others to disprove once more a view that has long been discarded. "Frail" is the last epithet that anyone who has had anything to do with women students would be likely to apply to them; for myself I would rather describe them as "toughs."

Having spent twelve years on the teaching staff of one of the schools that still caters for both sexes, I have long been a convinced advocate of further provision for co-education in our London schools; but I do realise that there are great difficulties and considerable danger in any attempt to provide it, and I shudder at the thought of the disaster that lies in store for any school that makes the attempt without realising the difficulties and making all possible efforts to guard against them. I would like to mention two essentials, the absence of which in my view puts the admission of women quite out of court at Guy's unless radical alterations are made; these are ample clinical material and adequate housing accommodation. There is no need to say much about the former; your columns have borne frequent testimony to the excessive number of students already admitted relative to the clinical material available, and schemes to limit the number of students have apparently received serious consideration by the school authorities. To admit women under such conditions would be, not merely folly, but a crime against men and women. The problem of accommodation requires a little more emphasis because there is some suggestive evidence that the Guy's authorities pay little attention to it. In some earlier discussion Professor Ryle observed that the necessary accommodation could probably be provided by the Matron in the Massage Department; this may not have been so absurd as it sounded to me, but I find it difficult to believe that this department has been so overhoused as to be able to supply anything like the amenities that would be needed. Moreover, there is no hope of getting a smoothly running mixed school until the men have been decently housed.

For many years Guy's students have had to put up with accommodation that may be mildly described as cramped and squalid. A medical school, like individuals, must cut its coat according to its cloth, and when the authorities say that they cannot provide anything better the statement must be accepted. The enthusiasts for co-education, however, may rightly be asked not to add insult to injury by gratuitously admitting women, particularly when the insult is to the women, too. The complexity of the problem has been mentioned by the M.P. for London University in a recent letter to the Press, wherein he stated that the difficulties were under the careful consideration of the University; I have only mentioned two which past experience leads me to believe are of special importance at Guy's. The ideal, to my mind, is to have three types of schools—one for men only, one for women only and one co-educational. The London schools differ from each other in those varied characteristics which we group together loosely under the term "atmosphere"; it may well be that the atmosphere in some schools is more suitable for taking women than in others. Some may think that these differences in atmosphere are not worth preserving. I think they are; but whether this is so or not, the most foolish argument ever put forward for the admission of women to all London schools is that what is possible in the provinces or in other countries is necessarily practicable or desirable in London.

Yours, etc.,

GORDON W. GOODHART.

The Inferior Alveolar Nerve and the Fractured Mandible

By JOHN W. HALLAM, M.R.C.S., L.D.S. (Eng.).

ANÆSTHESIA of the area supplied by the inferior alveolar nerve is a frequent finding in cases of mandibular fracture; it may be partial or complete. The associated injuries may be of such severity that no mention of this symptom is made; on the other hand, *a history of anæsthesia, as a sequel to external trauma, is often the sole indication of fracture*; the only alternative diagnosis being injury to the mental branch after its emergence from the mental foramen.

The influence of this anæsthesia has a considerable bearing on the subsequent oral hygiene; food debris, not being detected by the lip or the cheek, tends to stagnate in the buccal sulcus unless it is sought out and removed mechanically, the patient being instructed to clean out this area after each meal. Further, he should be warned of the care needed to prevent him cutting himself when shaving, or burning himself when smoking.

Particular watch should be kept for any tendency of the splints or wires to chafe; rough or sharp edges being eradicated, covered with gutta-percha or dental composition.

The anæsthesia may, at times, be made use of; teeth anterior to the fracture can often be extracted without further anæsthesia, provided the fracture is adequately splinted beforehand.

The length of time taken for sensation to return varies from a period of days to many months or even years.

Reviews

Midwifery. By TEN TEACHERS. Published by Messrs. Ed. Arnold. Seventh edition. *Price* 18*s.*

THE new edition of this text-book is shortened by removal of redundant statements and repetitions, and now consists of 545 pages and 232 illustrations. It is improved also by a decrease in size and a more logical arrangement of chapters, which have all been revised. In this edition normal pregnancy and labour are considered before

their possible complications; modern work on the placenta; the use of sulphonamides in obstetrics and the new classification of abnormal pelves are included. The book is recommended to students who want a practical text-book on midwifery with the information needed for their final examination.

T.L.T.L.

Prescriptions and How to Read Them. By A. L. MORTON. Published by Messrs. Faber & Faber. *Price* 2*s.* 6*d.*

THE section on Materia Medica in this little book is good, though a more strict alphabetical arrangement of the drugs would be an advantage. The comparison between the English and metric weights is given in far greater detail than a nurse needs and, for this reason, is confusing. Also the chapter on incompatibles, though interesting to those who have a considerable knowledge of chemistry, is beyond the understanding of most nurses. H. M. G.

Lectures to Nurses. By M. S. RIDDELL. Published by Messrs. Faber & Faber. *Price* 7*s.* 6*d.*

THE eighth edition of this book contains many useful additions to the text. It still, however, is not a really up-to-date text-book of nursing. For instance, hot fomentations are still a treatment recommended for boils and carbuncles; castor-oil is given as a purgative before operation; ear-syringing is given as preparation for mastoidectomy; and rectal ether as the method of anæsthetising a patient for thyroidectomy. The only surgical method given of treating a gastric ulcer is gastro-jejunostomy. Many other instances might be given showing that very careful revision is necessary. In spite of this, nurses find much good nursing material in the book. It is easy reading and cheap for the amount of matter contained. H. M. G.

Materia Medica for Nurses. By A. MUIR CRAWFORD. Published by Messrs. H. K. Lewis & Co. *Price* 4*s.*

THIS is a cheap and practical handbook on the nature and use of substances used as medicines. It does not deal with the pharmacological action of drugs except in the barest detail. If at any time this aspect of the subject could be developed more fully the book would be much more useful to nurses who take a simple examination in pharmacology, such as is held at Guy's Hospital. In the meantime, it is still a most useful book for nurses. There are the usual appendices, tables, doses, abbreviations and preparations clearly and simply set out. Then all the important drugs in use are dealt with in turn, their origin, preparations in common use and the conditions for which they are prescribed. H. M. G.

Dietetics by Rosamund Wansbrough. Published by Messrs. Faber & Faber. *Price* 4*s.*

NURSES who are doing a course of sick-room cookery and dietetics in the Preliminary Training School will find much to interest and enlighten them in this book. Food values and vitamins are clearly explained in sufficient detail. The second part of the book, which deals chiefly with diet in the various diseases, will be useful to those working in medical wards. The practical aspect of serving meals, laying trays, choice of menu, and coaxing the patient to eat is a good feature. Diet plays an important part in the nurse's work. In these days, particularly, they must learn all they can of food values and see that from the supplies obtainable a balanced diet is obtained and served in an appetising way. H. M. G.

Handbook of Practical Bacteriology. By T. J. MACKIE, M.D., D.P.H., and J. E. MCCARTNEY, M.D., D.Sc. Published by E. & S. Livingstone, Edinburgh. Sixth Edition. *Price* 17*s.* 6*d.*

FOUR years have passed since the last edition of this useful handbook on practical bacteriology. The many advances made in this period have entailed considerable revisions in the text and some additions, but, in spite of this, the volume still retains a handy size.

The work is divided into three parts, the first being an introduction to the morphological characters of bacteria, the methods employed in the laboratory for their identification, and a brief account of the mechanism of immunity. The second part is devoted to laboratory technique, the third to the morphological and cultural details of the individual pathogenic and commensal micro-organisms. An appendix has been added in which, among other things, a short account has been given of the mode of action of the sulphanilamide group of drugs.

As the title states the book is a practical one and most space is given to the description of technique and methods employed in the laboratory. For this reason its greatest use is to the bacteriologist and technician, for whom it forms a valuable reference. For the medical student much of this practical detail is unnecessary and he would profit by more theory. However, for senior men, the first and third sections read in conjunction with practical classes would be very valuable and helpful.

For teaching purposes a more strict adherence to the modern method of classification and more prominence to the new terminology would have been an advantage. As it is, the grouping of unrelated organisms tends to lead to confusion. This is but a minor point, and does not detract in any way from the accuracy and general excellence of the book, which in the past has held its place as a laboratory reference work of the highest order. The present edition more than maintains its reputation.

C. W. T. S.

A Text-book of Bacteriology. By R. W. FAIRBROTHER, D.Sc., M.D., F.R.C.P. Published by Messrs. William Heinemann. *Price* 17*s.* 6*d.*

THIS book, now in its fourth edition, has been designed and written for the medical student. It presents only those branches of bacteriology that are of medical importance. Technical detail and laboratory methods have been reduced to the minimum, and bacteriology as an aid to prevention and diagnosis of disease has been stressed.

The arrangement of the book is excellent, description is clear and the text is well supplied with illustrations.

The bacterial nomenclature recommended by the Society of American Bacteriologists has been used throughout, and this greatly assists the reader in gaining a clear understanding of the relationship of the various organisms.

A short account of the sulphanilamide group of drugs and their mode of action has been included in this edition, and the whole work has been brought completely up to date to the time of going to press.

Altogether an excellent book for the medical student, giving him a clearly written and concise account of modern medicinal bacteriology. C. W. T. S.

Textbook of Surgical Treatment, including Operative Surgery. Edited by C. F. ILLINGWORTH. Published by E. and S. Livingstone, Edinburgh. *Price* 28*s. net.*

THIS book deals with surgical treatment in its widest sense, with very proper concentration upon the indications for and against operation, pre-operative preparation and post-operative care. The details of operative technique are discussed briefly with excellent illustrations and the book as a whole makes very interesting reading.

It is difficult, however, to decide what is the place of such a book. It is "intended mainly for senior students and those undergoing training in surgery." For the undergraduate student it is surely wrong to separate surgical treatment from the other equally important aspects of the subject. The principles of treatment so well expressed in this book could easily be incorporated in Professor Illingworth's well-known and very popular "Short Textbook of Surgery." There would then result a compact and almost ideal textbook which could safely be recommended for all qualifying examinations. For the post-graduate student the book is not full enough to satisfy his needs.

There is little fault to find with the subject-matter apart from minor differences of opinion which are not worth recording. Two statements on page 143, however, seem to call for correction; here the plasmacytoma is said to be "one of the most common of primary bone tumours" and the majority of cases are said eventually to "end as cases of multiple myeloma." Few people would accept either of these statements as true. Chapter I, a general discussion on pre-operative and post-operative care, is the weakest in the book. The common fallacy of heart disease as an operative hazard is perpetuated, whilst not nearly enough is said of affections of the respiratory system. Surgical affections of the kidney receive scanty recognition, and jaundice is not mentioned. The details of fluid administration are not clearly expressed and, in some instances, do not agree with modern opinion. The remainder of the book is well worth reading for reading's sake by anyone interested in surgery. S. H. W.

Sport

Hockey

1ST XI *v.* ST. MARY'S HOSPITAL.

(*At Teddington on Saturday, December 5th.*)

Illness and exams. necessitated changes in the team. Dawson came in for Glover at left back and played an excellent game. Wotton did quite well on unfamiliar ground at outside left, Parry being moved over to inside right. Guy's scored early through a brilliant individual run by Saunders, which ended in hard "flick" goal. Burt scored soon after from close in. For the remainder of the first half the game was fairly even and St. Mary's scored shortly before the interval. There were no further goals. Guy's did most of the attacking during the second half and had several near misses, one ball hitting the post with their goalkeeper beaten. Smith was very safe in our goal and cleared strongly.

Team.—E. S. Smith; B. H. Prideaux, D. C. Dawson; J. R. Dimock (captain), J. G. Richards, P. T. Parr; G. Thompson, T. C. L. Parry, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

Association

The season 1942–1943 is the first time an Association football team has been functioning in Guy's since before the War. Fixtures have been obtained with most of the Soccer playing hospitals, the banks and a number of Service teams. The close of the first half of the season has been exceedingly gratifying, and results show it has been well worth while the effort to start the team again:—12 matches played, 11 matches won, 1 match lost. Goals for, 84; goals against, 16.

All the hospitals, including St. Thomas's, St. Mary's, and U.C.H. have been beaten and the one reverse was the first match we played against a fitter Army XI.

Leading goal scorers to date are:—R. D. Rogers, 22; E. G. Murphy, 20; R. Finney, 18; J. Elder, 15.

In spite of one or two enforced alterations in the team due to illness the composition has remained fairly constant, viz., from N. Crane, R. Macneil, R. Middleton, R. Young, D. Middleton, C. Matthews, W. Stapleford, W. Munroe, E. G. Murphy, J. Elder, R. Rogers, R. Fairey.

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

FIRST AND SECOND PROFESSIONAL EXAMINATION.

L.D.S.
December, 1942.

Dental Metallurgy.

T. L. Barker	R. G. Iliffe
R. K. Foster	G. A. Kerr
D. G. D. Harris	W. O. King

Dental Mechanics.

D. A. Barr	K. M. Little
C. C. Bull	A. G. Starte
J. F. H. Flanders	E. H. Sudell
D. J. Gray	B. Wotton
P. Griffiths	

Anatomy and Physiology.

J. E. E. Attale	P. C. Matthews
J. F. Bowes	J. D. Rumble
G. T. Crook	P. B. Smith
D. W. Farren	E. M. Sycamore
J. F. H. Flanders	I. D. L. Thomson
H. C. Goudge	C. J. L. Wheatley
M. C. Grant	E. J. Williams
W. D. Hannaford	E. H. Williams
C. M. M. Jenkins	

Special Anatomy and Physiology.

T. T. Billingham	D. T. Humphris

UNIVERSITY OF LONDON.
THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.
December, 1942.

Pass.

D. J. Anderson	H. C. Miller
G. A. Brown	T. A. Morris
T. P. Cheevers	J. Rankin
J. R. Halden	N. Stark
P. H. S. Lahaise	

Supplementary Pass List.

The following Students have passed in Group II.:—

H. C. Martin	M. C. Rosen
B. W. Pett	

UNIVERSITY OF LONDON.
FIRST EXAMINATION FOR MEDICAL DEGREES.
December, 1942.

Internal Students.

J. H. Baylis	E. T. King
M. P. Cardew	A. G. McCallum
N. Davis	T. E. Oppé
K. E. Hodge	D. J. Sheerboom
D. G. Jones	P. R. Wagner
B. J. Keene	P. J. C. Wallis

External Students.

G. C. Ambrose	R. L. Luffingham
R. A. Keable Elliott	T. G. Pugh
H. M. Hughes	P. Wilson
S. P. Johns	

UNIVERSITY OF LONDON.

SECOND EXAMINATION IN DENTAL SURGERY.

PART I.

S. G. Le Strange Beaton	A. Ferrari
	G. A. Morrant
A. J. Brunnen	B. H. de C. Prideaux

The following Students are credited with :—

Anatomy and Physiology.

S. J. Bell	J. G. L. Knowles
G. B. Elphicke	S. F. Lamb
J. J. Fingard	J. T. Woodall

PART II.

N. J. Crane

UNIVERSITY OF LONDON.

M.D.

December, 1942.

BRANCH V. (Hygiene).

H. W. Catto

UNIVERSITY OF OXFORD.

B.M., B.Ch.

December, 1942.

D. M. Strathie C. S. Gardner

Papers by Guy's Men

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New Year's Honours

O.B.E. (Civil Division)

Bernard Moiser, M.B., D.P H

C.V.O.

Charles Sculthorpe Morris, M.R.C.S., L.R.C.P., L.D.S.

Mentioned in Dispatches

The following Guy's men have been mentioned in recognition of gallant and distinguished services in the Middle East during the period November, 1941, and April, 1942 :—

Capt. H. M. Kelsey, R.A.M.C.

Capt. (Temp. Major), H. M. R. Knight, R.A.M.C.

Capt. C. G. Pantin, R.A.M.C.

Killed in Action

Surg.-Lieut. R. L. Greenfield, R.N.

Marriage

STILL — MacKISSOCK. — On December, 30th, 1942, at the King's Chapel, of the Savoy, Hereford, Crossfield Still, M.B., B.Ch. to Helen MacKissock.

KIRKMAN—MaCABE.—On December 27th, 1942, at Staplehurst, Kent, A. H. B. Kirkman, F.R.C.S.E., F.L.S., to G. Evelyn McCabe, M.D., B.S. (Lond.).

Births

HUDSON-EVANS.—To Vivienne (née Livsey) wife of Squadron-Leader R. Hudson-Evans, R.A.F.V.R., the birth of a son, on December 3rd, 1942, at Heswall Nursing Home, Heswall, Cheshire.

TRETHOWAN.—On January 11th, 1943, at 19, Bentinck Street, to Pamela (née Waters), wife of W. H. Trethowan, M.B., B.Ch., a daughter (Gillian Mary).

Deaths

FRASER.—On January 7th, 1943, at Fir Mount, Frant Road, Tunbridge Wells, Alexander Fraser, M.B. (Lond.), aged sixty-eight, second son of the late Alexander Fraser, of Blackheath.

LANE.—On January 16th, 1943, at 46, Westbourne Terrace, W.2, Sir William Arbuthnot Lane, Bt., C.B., M.S., F.R.C.S.

MARCH.—On January 15th, 1943, at Reading, Edward Gerald March, M.D. (Brux.), F.R.C.S. (Edin.), M.R.C.S., L.R.C.P. (Lond.) of Castle Hill, Reading, in his seventy-fourth year.

EDS. { H.B.F.O. P.F.E.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVII. No. 1423 *6th February, 1943* *Ninepence*

PASSIM

NOW we can assess how well we learnt our lessons at Guy's during the interval since 1940 and the air-raid warning that sounded a few Sundays ago. The evacuation of the wards was accomplished very smoothly and, although it took longer than the ideal of twenty minutes, was a very creditable performance by those on duty that night. The time factor, of course, was lengthened by the fact that the students on the rota, and for that matter many of the nurses on the wards, were just starting a new appointment and therefore unrehearsed. The evacuation of the upper floors of Hunt's House to the basements of the rest of the Hospital buildings does not, of course, make the patients any safer from high explosive, but does enormously facilitate their protection in case of fire. There are numerous fire-escapes in the Hospital, and they were used in 1940—but the portage of patients down those escapes, especially under " blitz " conditions, is and was no easy task ; even now our imagination reeled when we heard the story of a patient manhandled down those escapes, a patient weighing sixteen stones and incontinent of both fæces and urine. At the present moment the Hospital has been provided with a trailer pump and so, presumably, will not have an absolute priority call on the Fire Service, but assuming that incendiaries if they fall will not fall singly but in large numbers, and remembering how small a number of people we have to deal with them, it is no wonder that the Hospital authorities are insistent that the patients should be moved to such positions so that rapid change of places in case of fire can be easily carried out.

WE hope all our readers will remember a letter printed in the *Gazette* a few weeks ago about a nurse losing her way in the maze of underground passages, eventually dying and haunting those places since. The sequel to that letter may now be told. A few days ago one of our Sunday newspapers telephoned to the *Gazette* office asking for more information about the tragedy and requesting that reporters and photographers may be allowed access to a " story." Alas, that neither of the Editors was present in the office when this call was made—they would have had a " story " that would long be remembered both in the written and unwritten history of Guy's.

IT may be of interest to those now at Guy's, particularly the new arrivals from the Sectors, that Matt Wells, ex-lightweight champion of England, and now boxing coach to Guy's and to United Hospitals, comes up to the gym. to give instruction every Wednesday afternoon. Lately there have not been enough boxers at Guy's to form a whole team, and in any case the inter-hospital championships have been abandoned during war-time, so the only plan in view is to try and include as many Guy's men as possible in the United Hospitals' side. Anybody, whether boxer or not, is welcomed at the gym., and a bit of exercise under Matt Wells's eagle eye will abolish many a pre- or post-examination depression.

THOSE of you who read this fascinating little periodical right through to the bitter end will notice a change in the initials hid so diffidently under a line. Mr. H. B. F. Ordish has had to relinquish his share of the Editorial seat. The *Gazette* owed much to his tact and ability, and we wish him all the success in his new appointment and in his future career. We are pleased to be able to say that Mr. J. O. Laws has agreed to fill the vacancy as Assistant Editor, and we are sure that no better choice could have been made.

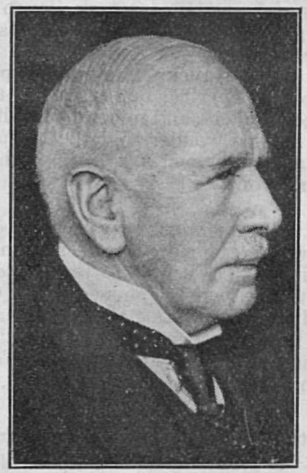
Also leaving Guy's to go into the Forces and taking our best wishes with him is Dr. Darke, well known to many Pre-clinicals. Their new Mentor, and assuming the title of Medical Tutor, is Paul Fourman, whom we welcome back from the Sector.

WE regret to report the death of Mr. M. F. Hopson, L.D.S., R.C.S., consulting dental surgeon to the Hospital since 1927. A memorial service was held at the Chapel, Guy's Hospital, on Tuesday last (February 2nd), and we hope to be able to publish an obituary in our next issue.

Obituary

SIR W. ARBUTHNOT LANE, BART., C.B., M.B., M.S. (Lond.), F.R.C.S. (Eng.); Consulting Surgeon to Guy's Hospital.

WILLIAM ARBUTHNOT LANE was born in Scotland on July 4th, 1856, the eldest son of the late Brigade-Surgeon B. Lane, M.S. He was educated at Stanley House, Bridge of Allan, and came to Guy's when a little over sixteen years of age, thus beginning an association which was to last for seventy years. Living as he did through the grand period of surgical advance, Lane was always in the forefront of the pioneers, and it was he who first brought into practice at Guy's the principles of aseptic surgery. The many contributions which he made to the advance of surgery were throughout distinguished by two characteristics, originality in conception and perfection in execution, and none who witnessed his work will gainsay that he must be ranked among the greatest technical operators of his or any other age. His early work at Guy's was done in the dissecting-room, where he already showed his interest in fractures. There he made many observations, and wrote many papers on the adaptation undergone by the skeleton in consequence of the stresses and strains to which it is exposed by differing occupations, as exemplified in particular in the case of the coal-heaver and the shoe-maker. At this time also —1885—he began, while a newly appointed assistant surgeon at Great Ormond Street, the practice and advocacy of re-section of part of the rib for the drainage of empyæma, which brought down on him the wrath of many physicians, an experience which to him was to be the first of many similar ones, and which affected his views not at all. Papers on extravasation of urine, the anatomy and pathology of the hip-joint and many more and varied observations followed rapidly, and in 1883 he became interested in lateral sinus thrombosis, for which condition he was one of the first to perform ligature of the jugular vein. At about this time Lane divised his cleft palate operation, which represented a great advance in surgical procedure, while the observations which he made on the effects of mouth-breathing on the arch of the palate gained general acceptance. In 1893 papers on "the fallacy of the vertical footpiece," and the "applicability of the angular gouge to the surgery of the skull" were evidence of the dissatisfaction which his mechanical instincts felt at the current practices of bone surgery, and in that year appeared his first paper on "the advantages of the steel screw in the treatment of ununited fractures." The introduction of saline solutions into the circulation to replace blood lost by hæmorrhage, laminectomy for paraplegia, the uses of sulphur in surgery, and a modification of the current operation for carcinoma of the breast show the breadth of his interests



Press Portrait Bureau

At about this period—1895—he began his work on the operative treatment of simple fractures. In appraising the value of this work from the standpoint of to-day two things must be kept in mind. Firstly, the poor general level of treatment at that time, which his insistent advocacy and practice of perfect anatomical reposition of the bone did so much to improve; and, secondly, the technique which he evolved and which became known all over the world as the Lane "no-touch" technique. Many have emulated, but none have surpassed, the perfect surgical artistry with which he performed these operations and his method remains to-day the ideal to be followed in all bone operations. Stimulated by the views of Metchnikoff, Lane then became interested in the surgery of the colon and his advocacy and practice of complete colectomy for the condition which he termed "chronic intestinal stasis" led to much and often bitter controversy. Arbuthnot Lane, however, thrived on opposition, and though even to-day there are some who do not admit the validity of all his concepts, none could doubt his sincerity or fail to admire the brilliance of his technical achievement. Lane was never

a great lecturer or speaker, but he had what is, perhaps, the greatest attribute of the teacher—the ability of inspiring enthusiasm and keenness in all those who came under his influence. He was a strong man, physically and mentally. He could tire out the keenest of his assistants and remain fresh and unperturbed himself. He would follow the line he had laid down for himself, utterly uninfluenced by opposition or criticism.

Lane loved Guy's, and many generations of Guy's men and women will in their turn remember "Willie Lane," as he was generally known with affection. The calls of a large practice never led him to miss his meticulously punctual attendance at the Hospital, where his theatre was usually thronged by spectators, including many distinguished visitors from all over the world. A progressive mind led him to be one of the chief advocates of the early development of special departments at Guy's, though his aphorism that "the development of a special sense is apt to lead to the loss of common sense" showed that he was alive to the dangers of that policy. During the World War, when he served as a colonel in the Aldershot Command, he had much to do in conjunction with the late Professor Tonks in establishing the first plastic unit, so brilliantly developed by Sir Harold Gillies. Arbuthnot Lane was personally the kindest of men. His loyalty to his friends was unbounded, and many there were who owed to him their opportunities and their advancement. Hospitable to a degree he delighted in entertaining his visitors, and he in turn on his many visits abroad, and particularly to the United States, received in full the acclaim and recognition which were his due. Arbuthnot Lane was too turbulent and combative a personality for his place in surgery to be easily assessed at the present time. That he was outstanding in his age all would agree, and where he will always occupy a place high in the ranks of distinguished and honoured Guy's men.

Correspondence

POST-WAR RECONSTRUCTION OF GUY'S.

To the Editor of the GAZETTE.

SIR,—The plans for the post-war reconstruction of Guy's are already under consideration and, as the War progresses, attention is bound to be focused more and more on the physical lay-out of the new Guy's. It appears most probable, if not indeed certain, that the south side of St. Thomas's Street from the Matron's house to "The Grapes" is likely to be involved in a rebuilding scheme, which will abolish St. Thomas's Street as residences for members of the Guy's staff and junior staff.

I believe that one of the chief factors which has contributed to the extremely close and friendly relations between staff and students, so characteristic of Guy's, has been the tradition that junior members of the visiting staff and many of the registrars and teachers should live closely adjacent to the Hospital. Indeed, at least three members of the present visiting staff were appointed only on the condition that they lived in St. Thomas's Street and apart from these a majority of the present members of the staff have lived in or around the Hospital for a number of years during the earlier part of their careers.

I feel, therefore, that any committee which is dealing with post-war planning should bear in mind the desirability of providing adequate residential facilities in the immediate vicinity of the Hospital. While it may not be necessary or desirable to compel all junior members of the visiting staff to reside near Guy's, I am certain that the abolition of St. Thomas's Street, as we knew it pre-War, is likely in the end to have unfortunate effects, unless substitute living accommodation is provided for members of the junior and of the visiting staff.

It seems probable that the College and Students' Club will be completely rebuilt and I venture to suggest that in conjunction with whatever scheme is adopted there should be incorporated a number of flats, which the Hospital or School could rent to members of their staff. I believe that it is only by some such plan that we can preserve that somewhat indefinite but nevertheless real entity, the Guy's spirit, which is primarily the close and intimate co-operation and friendship between students, house officers, junior staff and visiting staff.

Yours, etc.,

J. J. CONYBEARE.

Nuffield House,
Guy's Hospital, S.E.1.

Two Clinical Cases and a Description of Trichlorethylene

A Clinical Lecture delivered at Guy's Hospital on 28th September, 1942, by A. D. Marston, D.A., M.R.C.S., L.R.C.P., L.D.S.

GENTLEMEN,—In the administration of an anæsthetic three primary factors are present—firstly, the general condition of the patient; secondly, the toxicity of the anæsthetic agent; and, thirdly, the personal skill of the anæsthetist. This last factor is of the highest importance, and the realisation of this possibly accounts for the endeavour of many anæsthetists to confine their choice of anæsthetic agents to those with which they are most familiar and in the use of which they are most expert. But there is, unfortunately, no anæsthetic of universal applicability, and we should accordingly accustom ourselves to the employment of a wider range of anæsthetic agents.

In two recent cases routine anæsthesia was deemed unsuitable. One was a man of eighty with an acute abdomen, and the other was an infant of twenty days requiring circumcision. By the term "routine anæsthesia" I mean the type usually employed. Contemporary practice largely consists of balanced anæsthesia—*i.e.*, premedication, basal narcosis, and maintenance anæsthesia, this last being usually secured by means of a machine which delivers nitrous oxide, oxygen, and adjuvants such as ether, chloroform, vinesthene and trilene.

Another type of anæsthesia routinely used by anæsthetic specialists consists of gases such as cyclopropane and helium in a closed circuit. There is also the slowly evolving technique of continuous intravenous injection of the barbituric derivatives, with or without supplementary inhalation anæsthesia.

Let us consider for a few moments the choice of anæsthetic in the two cases mentioned, which illustrate the wide disparity of age and physical condition which may be encountered in the daily practice of any anæsthetist.

CASE I.—Male, aged eighty years. *History.*—A few hours before operation he was seized with sudden abdominal pain and suffered a certain degree of collapse. His physician ordered his immediate removal to a nursing institution, where he was examined by Mr. Slesinger. Following this examination he was given omnopon, gr. 1/3, to relieve pain, and was prepared for laparotomy.

An examination—even if only brief—should always be conducted by the anæsthetist also. In the case in question our examination showed a man, well preserved for his age, with no gross change in the lungs, but a pulse somewhat quick and feeble. The pupils were contracted, the complexion pale, and the respirations shallow; the previous medication had not only relieved pain, but was still acting strongly.

Choice of Anæsthetic.—The safety factor was of primary importance in a case such as this. Spinal analgesia was contra-indicated, as was also, in my opinion, the intravenous injection of any of the barbituric derivatives. The danger in mind was a sudden fall of blood-pressure or respiratory depression leading to collapse.

Atropine, gr. 1/100, was given, and induction was carried out with nitrous oxide gas and oxygen. As is usual in such a condition as this, and as has so often been observed in the last and the present wars, this simple anæsthesia yielded a flattering result. It might well have sufficed for the laparotomy, but it is now well recognised that these cases require more oxygen than is commonly administered with nitrous oxide if the grisly alliance of shock and anoxia is to be prevented. Therefore, as an adjuvant, trilene was added, and then a little ether to a mixture of nitrous oxide 50 per cent. and oxygen 50 per cent., thus securing adequate oxygenation and muscular relaxation.

Laparotomy revealed an extensive mesenteric thrombosis, and a fairly wide resection of intestine with end-to-end anastomosis was speedily performed. The patient stood the operation well and made an excellent recovery. Some ten days later, however, a fresh abdominal crisis occurred and he succumbed to a fatal collapse.

CASE II.—Infant, aged twenty days, breast-fed and in perfect physical condition. As the operation was timed for 9 a.m., the usual feed was given at 6 a.m., atropine, gr. 1/200, being injected subcutaneously at 8.30 a.m.

Choice of Anæsthetic.—The safety factor was again of primary importance. Induction of anæsthesia is seldom easy in infants, as they tend to struggle a good deal and seem to require a considerable amount of anæsthetic before the third stage of anæsthesia is attained. Once this stage has been reached, surprisingly small additions of anæsthetic produce deep—and sometimes dangerously deep—anæsthesia.

For an infant of this age I do not believe in any basal narcosis because it tends to reduce the safety margin. Atropine is used because an infant so readily secretes mucus; furthermore, it acts as a prophylactic agent against vagus inhibition with chloroform. Nitrous oxide gas and oxygen may be used for induction, but I personally do not advise this unless the infant has a pulmonary complication or is suffering from jaundice. Anoxia is readily produced with the use of gas and oxygen, and the heart muscle of an infant requires an adequate supply of oxygen and cannot tolerate an insufficiency.

Induction may be carried out with chloroform, ether, or a combination of the two upon an open mask. Ethylchloride should be avoided as it causes a rapid secretion of mucus and may produce spasm of the glottis; furthermore, the anæsthesia is in any case too rapid and evanescent.

In the case under discussion an open mask was used with a single layer of flannel, and chloroform was given in slow drips during the first minute, after which ether was dropped on until the light plane of the third stage was gradually reached. A small airway was then introduced, the mask removed, and a gentle stream of oxygen and warm ether given. The whole face was under constant observation, and only small amounts of ether were used during the sixteen minutes which the operation took to complete.

The baby made a rapid recovery and, although in a somewhat dazed state, was able to take its next feed at 10.15 a.m. The child slept for a while after this feed and took the following one in a normal manner. There was no vomiting or other post-operative complication. This was probably due to the small total amount of anæsthetic given and to the timing of the breast feeds.

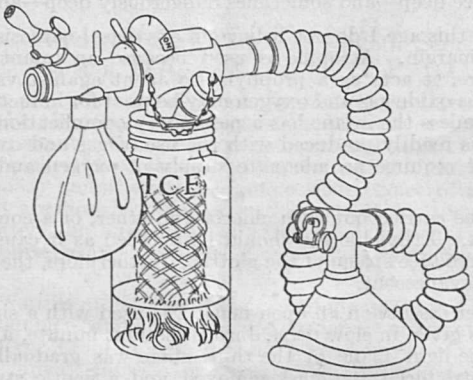
Trichlorethylene.—During the past year many anæsthetists have used this agent as a general analgesic and anæsthetic. The drug has been known for many years, but its use in medicine has hitherto been confined to therapeutic inhalation for the relief of trigeminal neuralgia and as an external application in the treatment of burns and infected wounds. In commerce it is used for the dry cleaning of clothes, and the removal of grease from metals. Dr. C. Langton Hewer, in his admirable paper[1], which I advise you to read, records the fact that industrial workers are prone to inhale the fumes of trichlorethylene from open vats and are said to experience "considerable pleasure" therefrom. Such inhalations contain impurities, and addicts are liable to suffer from unpleasant symptoms such as giddiness, vomiting and optic neuritis[2]. Experimental work on animals reveals the fact that trilene is only slightly toxic and compares favourably with other lipoid solvent narcotics[2].

Under the ægis of the combined Committee of the Medical Research Council and the Anæsthetic Section of the Royal Society of Medicine, Dr. C. Langton Hewer has carried out a complete investigation of the properties and possibilities of the anæsthetic, and the following details are, by his kind permission, mainly derived from his report.

Physical Properties.—Trichlorethylene is a colourless fluid with an odour similar to but less pungent than chloroform, and is not very volatile, having a boiling point of 87 deg. C. and a specific gravity of 1.47 at 15 deg. C. The drug is liable to decompose if exposed to strong sunlight and should, therefore, be stored in amber-coloured bottles. This tendency to decompose is reduced if 0.01 per cent. thymol is added. The product is manufactured under the name of "trilene," and is coloured blue so as to distinguish it from chloroform. The chemical formula is $CCl_2 : CHCl$. Like chloroform it has three chlorine atoms in its molecule, but, unlike that drug, it does not usually cause cardiac effects other than irregularity of the pulse, and even this is of less frequent occurrence than it is with the use of cyclopropane.

Administration.—Owing to its lack of volatility trilene is not satisfactory when used on an open mask. It may be used in the chloroform bottle of a Boyle's apparatus as an adjuvant to nitrous oxide gas and oxygen; but the best effects of the drug are obtained from Merrett's apparatus, an illustration of which is here shown. The use of a cotton wick and a small re-breathing bag enables the trilene to reach a greater concentration, and with its aid the third degree of anæsthesia may be attained. The

apparatus is simple in construction, efficient in service, and cheap in cost, the price of the outfit with one bottle being about five guineas. It consumes trilene at the rate of 13 cc. per hour, at an average cost of about 4½*d.* per administration.



Stages of Anæsthesia.—These are similar to those of chloroform, and there is the same characteristic small pupil in the third stage, accompanied by quiet respiration. Like chloroform, the drug should not be pushed beyond the third stage. If deeper narcosis is required it is better—and certainly safer—to add ether which will speedily produce the desired effect. It is interesting to note in Hewer's record that in a case of overdose with cessation of respiration, artificial respiration secured a speedy recovery, the pulse not stopping, but beating steadily during the period of respiratory arrest.

Clinical Observations during Anæsthesia.—Trilene being a bland and non-pungent vapour is easily inhaled and does not irritate the respiratory tract. It has been used with success in chest surgery and is indicated for subjects suffering from pulmonary tuberculosis, chronic bronchitis, and bronchiectasis. In a certain percentage of cases a marked quickening of respiration occurs, and this sometimes interferes with operations during which a tranquil respiration is desired. This phenomenon is less frequent when the drug is administered with air and not as an adjuvant to nitrous oxide gas and oxygen. Irregularity of the pulse is sometimes observed, but Dr. Webber, of University College Hospital, has remarked that it occurs less frequently after induction with an intravenous barbiturate, this having been our own experience at Guy's Hospital also.

Whether or not capillary oozing is increased is a debatable point. Some observers declare it to be less than with the use of ether and cyclopropane ; on the other hand, we have had a number of cases at Guy's in which hæmostasis proved more difficult than usual. Blood-pressure readings during maintenance anæsthesia show little variation from the normal.

Adequate muscular relaxation—one of the most inconstant effects of any inhalation anæsthetic—is not uniform with trilene. It suffices for the great majority of extra-peritoneal operations, but is only occasionally adequate for intra-peritoneal work.

It is interesting to note that Enderby, who has completed a carefully recorded series of over two hundred cases at Pembury, has remarked that if avertin be used as a basal narcotic, subsequent maintenance with trilene has often resulted in an adequate degree of relaxation for intra-abdominal operations, and there have been no immediate or post-operative adverse effects, such as might be expected from the use of two drugs with a constituent chemical arrangement similar to chloroform.

In contrast to ether and chloroform, trilene has little effect on the blood-sugar or the blood urea. Hewer records an administration to a diabetic patient lasting one hour and fifteen minutes without any untoward symptoms ; moreover, a week later, when the sugar tolerance was tested, it was found to be unchanged.

In midwifery there is great scope for the use of trilene. Its cheapness, its ready applicability and the ease with which analgesia can be attained make it a valuable

narcotic. When used for Cæsarian section the uterus has been observed to retract satisfactorily after delivery of the fœtus.

Not the least of its many virtues in these days of increasing use of the diathermy cautery is the fact that trilene is definitely non-inflammable and non-explosive.

In a recent issue of *The Lancet*, Dr. John Elam gave a favourable report of one thousand administrations of trilene, and expressed the opinion that it is a suitable anæsthetic for routine work in general practice. This may well be so, for trilene has many advantages and few disadvantages. But let us be sure that we suit the choice of anæsthetic to the patient. In this lies progress; the converse only constitutes a hindrance to better anæsthesia.

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The Ballot and the Congress of the B.M.S.A.

THESE two events took place just before Christmas and are of considerable interest in regard to the correspondence which is now going on, not only in the *Gazette*, but in all the medical press of the country.

The ballot, which was organised by the Students' Committee, was held to obtain the opinion of the clinical students at Guy's regarding the matter of women in Medicine and women being admitted to Guy's. There were three statements—A, B and C—posted on the board. These were :—

A. Women to be admitted to Medicine under a quota, so as to keep their proportion to men fixed. No admission to Guy's.

B. Women to be on an equal basis and to have the same opportunities as men in the profession, but no admission to Guy's.

C. Women to have complete equality with men and to be admitted to Guy's.

Students were asked to state with which statement they were in agreement. Those unable to find sympathy with any statement were asked to desist from voting. The result was exceedingly interesting. Of the 195 votes received there were 106 for *A*, 44 for *B*, and 45 for *C*. So on the single question of admission to Guy's the voting was 150 to 45. A similar ballot conducted at Sherwood Park showed the majority against admission of women. But it seems that not only do the students at Guy's wish to refuse admission to women, but that there is considerable feeling against them within the profession. The writer is recording facts without bias, but it would appear that the idea of women in medicine on equal terms with men is not as widely accepted as our mentors would have us believe.

Armed with this information the delegates from Guy's were able to proceed to the B.M.S.A. Congress and deliver the views of their constituents. This was the first Congress of the British Medical Students' Association, and it was held at B.M.A. House by courtesy of the B.M.A. It was a three-day affair and each day was there a distinguished speaker. There were the Minister of Health, Sir Charles Wilson and Professor Ryle. It is possible that some readers have never heard of the B.M.S.A. It is a newly formed body and it represents 80 per cent. of the medical students of Great Britain. Professor Hills' remarks before the Minister of Health spoke are worthy of note. He said that before a Minister would consent to attend a meeting there was considerable activity behind the scenes by his secretaries to determine, not only that the body in question was *bona-fide*, but that it was responsible and influential in its own field. He added that the presence of the Minister was a splendid omen for the inaugural Congress.

The most important business of the B.M.S.A. was to give approval to the memorandum on medical education, prepared by the committee. This memorandum forms the basis of a report to the Goodenough Committee, which is now sitting to consider reform in medical education. This memorandum is, therefore, both an interesting and important document. It can be studied in full in the Library and a précis of the business of the whole Congress can be read in the *British Medical Journal* of January 9th of this year. The memorandum was unanimously adopted by the delegates. It contains a recommendation that women should be admitted without reservation or distinction to all medical schools. In view of the general excellence of the report and the rather narrow issue at stake, the two delegates from Guy's decided not to vote against the adoption of the report on the question of admission of women. However, they decided to make known the views of the Hospital in the general discussion which followed the adoption of the memorandum. This was done and received in somewhat stony silence. The fun was fast and furious as ensuing speakers, including two from Guy's, debated the controversial point. Eventually, on a vote, it was decided that all the hospitals should be open to women on equal terms with men. But the chairman, with great diplomacy, suggested that it was a principle which was being decided, but that the committee quite realised that there would always be misogynist medical schools. Such tact satisfied everyone.

One other subject of immediate interest was discussed at length at the Congress. There was unanimous approval of the principle of staff student committees. Very few hospitals possess a body such as this, which can discuss freely the problems that affect staff and students, the teachers and the taught. St. Bartholomew's appears to have a good one, and one delegate from Guy's mentioned that the Sub-Dean was always willing to discuss teaching problems with the Students' Committee. Excellent and fruitful though these meetings are, they are neither official or held at regular intervals. Now that the principle is admitted, let us hope that a permanent committee with several members of the staff and students from every appointment may be founded.

"D.—C."

"Those Medical Bulletins"

"Straight from the bed the electric message came.
'He is not worse; he is just the same.'"

ONE can safely hazard a guess that the writer of the above soul-shaking couplet (supposed to refer, we believe, to one of the early Georges) was no Shakespeare, but he seems to have had the root of the matter in him—certainly not the root of poetry, but the root of this bulletin business.

How lacking in imagination are those bulletins which, of recent years, have emanated from the *chambres-a-coucher* of the illustrious great—"the strength is being maintained," or "not maintained," as the case may be. How many evening papers have been snatched up, only to reveal that arid morsel of news.

Our Sir Thomases and Sir Wilfreds surely lack the divine gift of imagination. Why, there is nothing that the public dotes upon so much as a piece of medical information couched in the most medical of terms. It does not in the least understand them, but it likes to think it does. Supposing that, on the next great occasion of ducal sickness that quite clever pharmacologist, Dr. Putsch, issued the following bulletin:—"My stimulating lotion was applied to His Highness's synapses, but—alack-a-day—his end-plates were quite worn out and he passed into rapid and complete oblivion." Just imagine how intoxicated with the mystery of it all would be that patient of ours who insists on complaining of a pain in his "thorax" or his "lumbar region," or, still more, the one (usually feminine) who makes loud moan of some totally imaginary dyscrasia of her "blood-stream," for that was very fashionable in Balham and Upper Tooting a few years before the War.

To the public, medical consultations, where they concern the great are hedged about with much mystery. The popular imagination pictures about a dozen patriarchal-looking figures, somewhat like the alchemists of old in appearance, gathered round the bedside. These, of course, are the Wise Men from the West. The popular imagination pictures them still further assembled round a large table muttering and brunting their various pieces of wisdom. We who have been initiated into these Eleusinian mysteries know how different it all is. The solemn histrionics around the bedside completed, the family physician, Sir Hugh Colocynth, trips lightly towards the bathroom, ostensibly *pour se laver les mains*, but we who know, know that the bathroom is the consulting room *par excellence* on these occasions. There, with Sir Hugh at the basin, and perhaps with Sir Ader Wurst on his right, with biochemist and hæmatologist and all the giddy throng perched and poised precariously on the edge of the bath, Sir Hugh addresses the assembly in the following portentous words: "Well, boys, what do you think of the old blighter?" A profound silence has up till now been the chief feature of the meeting, whilst Guy's eyes Bart.'s, and Bart.'s eyes Mary's as though to say, in the time-honoured manner of our ancient profession: "What *does* that fellow know about it, anyway?" However, the necessity to say something evokes from these Domes of Silence rumbles of varying degrees of pessimism such as: "Quite seedy," "moribund," "*in extremis*" —and so forth. Eventually the "seedys" are balanced against the "moribunds" and a bulletin is produced which usually reads: "The strength is being maintained." Of course, if it turns out to be the opposite the typist can so easily be blamed later on for having omitted the "not."

The main business of the day is now finished and, as they file out, the Lord Chancellor throws them each a purse of gold, or used to. Those were brave days, of course, for purse-makers; but now, with income-tax at ten shillings in the £, well—I ask you!

G. L. D.

Sayings and Quotations of Sir William Osler

Æquanimitas. Valedictory address, University of Pennsylvania, May 1st, 1889.

Sowing as you shall do beside all waters, I can but wish that you may reap the promised blessing of quietness and of assurance forever until you may, in the growing winters, glean a little of that wisdom which is pure, peaceable, gentle, full of mercy and good fruits, without partiality and without hypocrisy—

"Within this life,
Though lifted o'er its strife."

There are those present who will feel it no exaggeration when I say that to have known Palmer Howard was, in the deepest and truest sense of the phrase, a liberal education—

" Whatever way my days decline,
I felt and feel, tho' left alone,
His being working in mine own,
The footsteps of his life in mine."

Doctor and Nurse, Johns Hopkins Hospital, 1891.

You have been much by the dark river—so near to us all—and have seen so many embark, that the dread of the old boatman has almost disappeared, and your passport shall be the blessing of Him in Whose footsteps you have trodden, unto Whose sick you have ministered, and for Whose children you have cared—

" When the Angel of the darker Drink
At last shall find you by the river brink,
And offering his cup, invite your soul
Forth to your lips to quaff—you shall not shrink."

Teacher and Student, University of Minnesota, 1892.

When a man nor wax nor honey can bring home, he should, in the interests of an institution, be dissolved from the hive to give more labourers room ; though it is not every teacher who will echo the sentiment—

" Let me not live . . . .
After my flame lacks oil, to be the snuff
Of younger spirits whose apprehensive senses
All but new things disdain."

Reviews

Text-book of Medicine. By J. J. CONYBEARE, M.C. Published by Messrs. E. and S. Livingstone. *Price* 28*s.*

AIR-COMMODORE CONYBEARE has to be congratulated on managing to bring out a new edition of his text-book so soon after the last and under such difficult conditions. The necessity for a new edition after such short time proves the great popularity which this text-book, written mainly by Guy's men, enjoys.

The new features of this edition are mentioned in the editor's preface and there is no need to repeat them here.

The introductory chapters of the section on pulmonary tuberculosis contain quite a number of statements which are difficult to understand, and it seems a pity that so much space seems to be devoted to theory in what in most other sections is principally a practical book.

The section on glomerulonephritis contains no reference to recent work on the classfication of this disease. It cannot be expected that a renal specialist of Dr. Osman's experience should necessarily agree with these views, but since the text-book is meant to prepare students for their final examination in medicine it might have been extremely useful to mention this work.

Little is gained, however, by too short reference to recent work as is done in the chapter on blood transfusion. If we know that rhesus patients should receive blood only from rhesus donors we really know very little. The significance of the rhesus factor has recently been explained by one of the authors in the *Gazette*, and the subject was made very much clearer there.

Contradictions should be avoided in a text-book written by different authors and more so in different chapters written by the same author. The dose of sulphonamides advocated by the fever experts is half that given only a few pages later for septicæmia. On page 350 we are told that there is no true hæmolysis in pernicious anæmia, and on page 455 we find that the jaundice of pernicious anæmia is mentioned under the heading of hæmolytic jaundice. On page 511 it is stated that the drug of choice in auricular flutter is digitalis, and on page 514 that the effect of digitalis on any tachycardia except that of auricular fibrillation is doubtful.

The nervous manifestations of lead-poisoning and diabetes mellitus might have more suitably been considered in the chapters devoted to these diseases than under polyneuritis, where a short reference would have sufficed. Rabies, on the other hand, belongs more properly into the group of neurotropic virus diseases than amongst the tropical conditions.

The treatment of congenital pyloric stenosis with eumydrine deserves more than a sentence or two in a text-book of medicine, and the serum treatment of typhoid is only mentioned without giving any detailed instructions.

Much useful information is contained in the chapter on endocrine diseases and the discussion of such an important and common condition as the menopausal syndrome is to be welcomed, but one rather feels that hot flush counts rather lead to further introspection and ought to be discouraged.

The general remarks of chemotherapy are of great value and the warning against the indiscriminate use of the sulphonamides is a timely one. Similarly the stress laid on the limitation of gastroscopy is to be appreciated.

When reading the skin section one wonders whether lichen planus and vitiligo which have been left out are not commoner than dermatomyositis and scleroderma.

The great assets of this book are sufficiently known as not to need more than mentioning. The book is well written and the print such that it does not tire the War-time student when he returns from his Home Guard parade. The paper and binding remain amazingly good, on which score the publishers must be congratulated. The subject matter is, on the whole, extremely well arranged and there are few omissions and little irrelevant information. There is no doubt that this edition will be received as favourably as its predecessors by medical ward clerks, students taking their Finals and practitioners alike.

W. G. T.

Sport

Rugby

GUY'S *v.* MIDDLESEX HOSPITAL.

When the teams arrived at Chislehurst on January 9th the ground was unplayable, but a game of soccer was arranged and Middlesex entertained the players and their friends at a dance in the club pavilion.

GUY'S *v.* ROYAL NAVY, PORTSMOUTH.

(*Played at Portsmouth on January 16th.*)

Guy's visit to Portsmouth attracted a good attendance on the United Services Officers' ground. The first half was very scrappy, neither side being able to settle down to any combined movements. There was much improvement during the second period, when all the scoring was made. The Navy crossed for two unconverted tries, one from a scrum near the line, and the other from brilliant three-quarter play. Guy's solitary score came from a penalty kicked by Mullins.

Score: Royal Navy, Portsmouth, 2 tries (6 points); Guy's, 1 penalty goal (3 points).

Team.—P. L. Brangwin; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. D. Willcock; B. H. Wilshere, A. B. Lee, C. H. Kinder, A. G. Albers, I. H. Hilliam, P. D. Harvey, S. M. Hilton, M. R. Mullins.

GUY'S *v.* CAMBRIDGE UNIVERSITY.

(*Played at Cambridge on January 23rd.*)

Guy's visited Cambridge with practically their strongest side, but the handling of the back division left much to be desired, which threw a lot of work on the forwards. The University had to fight hard in the early stages, and A. C. Macrae-Gibson scored in the corner for Mullins to convert. Cambridge reduced the lead with a try by Wildman, but Mullins gathered the ball to touch down for a try which he failed to convert.

Cambridge had chances to score from a couple of penalties in the second half but failed, and Guy's returned to the offensive and almost scored. However, Langham scored for Cambridge from a forward rush, but in the closing stages Lewis converted a try by Wilshere, which gave Guy's a good margin, although their play was not up to expectations.

The writer believes this is the first time for forty years that Guy's have beaten both Universities in the same season.

Score: Cambridge University, 2 tries (6 points); Guy's, 2 goals 1 try (13 points).

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. N. H. Vann; B. H. Wilshere, A. B. Lee, R. G. L. Brittain, A. G. Albers, A. Batty Shaw, S. M. Hilton, C. Vidot, M. R. Mullins.

GUY'S *v.* ROYAL NEW ZEALAND AIR FORCE.

(*Played at Honor Oak Park on January 30th.*)

Against the R.N.Z.A.F. Guy's back division were on top form, and their perfect handling completely bewildered the New Zealanders. Not having to worry about dropped passes, Guy's forwards were able to play an open attacking game, and only occasionally were they called upon to defend, then Willcock would get the ball away quickly for another fast movement to develop.

The New Zealanders' movements were spoiled either by faulty passing or too much individualism, which enabled Guy's to cover any opponent in possession.

A. C. Macrae-Gibson, with a fine turn of speed, crossed for the first try, and following an excellent pick up by Willcock, the ball travelled to Micklem, who ran from half-way

to score under the posts. Both tries were converted by Mullins.

Following the interval, A. C. Macrae-Gibson was tackled close to the line, but managed to touch down in the corner. Then followed two beautiful tries. Strathie got the whole New Zealand defence out of position and sent a pass to Harvey, who had backed up splendidly, for a grand try, which was followed by Brangwin making a similar run with Brittain backing up to take the pass and to score under the posts. Lewis converted both these tries.

We are sorry to hear that M. R. (" Mike ") Mullins played his last game for Guy's. He has rendered splendid service to Guy's rugger by his sound leadership, and much of the team's success during the war period has been due to his amazing enthusiasm and skilful training of his forwards, in which he set, expected, and obtained a very high standard.

Result: Guy's, 4 goals 1 try (23 points); R.N.Z.A.F., nil.

Team.—T. L. T. Lewis, A. C. Macrae-Gibson P. L. Brangwin, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. D. Willcock; B. H. Wilshere, A. B. Lee, R. G. L. Brittain, A. G. Albers, A. Batty-Shaw, P. D. Harvey, C. Vidot, M. R. Mullins.

Hockey

GUY'S *v.* ST. BART.'S HOSPITAL.

(*At Honor Oak Park on January 23rd*, 1943.)

Won 5–2.

We were able to field our best side for this fixture and well deserved our 5–2 victory. Trethowan has now moved to outside left and played well in his new position. He has all the speed necessary for a wing forward and used it to run through Bart.'s defence by himself to score our last goal. Burt played an excellent attacking game and scored three more goals. Richards, at centre half, was the pick of the defence, playing his best game of the season. Parr was as sound as usual at left half.

We were the first to score, but Bart.'s equalised soon after, and we could do no better than 1–1 at half-time. Burt (2) and Saunders put our score up to 4–1 soon after the resumption. Bart.'s then fought back for a time and scored one more goal, but we were on top again at the end. Grummitt umpired the whole field very capably.

Team.—R. S. Smith; B. H. Prideaux, E. A. Glover; J. R. Dimock (captain), J. G. Richards, P. T. Parr; G. Thompson, T. C. L. Parry, J R. Burt, D. R. S. Saunders, J. D. Trethowan.

Hospital Information, etc.

Notice

POSTURAL AND REMEDIAL EXERCISES.

A demonstration of postural and remedial exercises, including the showing of the R.A.F. film, " Fighting Unarmed," has been arranged by kind permission of the Air Ministry, at the Seymour Hall, Seymour Place, Bryanston Square, London, W.1, on Wednesday, March 3rd, 1943, commencing at 6 p.m.

All registered medical practitioners are cordially invited to attend. Admission is free by ticket, obtained on application to the Acting Secretary, Board of Registration of Medical Auxiliaries, B.M.A. House, Tavistock Square, London, W.C.1.

Pass List

UNIVERSITY OF LONDON.

EXAMINATION FOR THE EXTERNAL DIPLOMA IN CLINICAL PATHOLOGY.

January, 1943.

R. C. Hill.

Change of Address

W. N. Mann, Captain, R.A.M.C., 92nd General Hospital, M.E.F.

H. J. Spon, Forge Cottage, Leigh, Tonbridge, Kent. Telephone: Hildenboro' 3117.

Mentioned in Dispatches

Ft.-Lieut. P. M. Davies, R.A.F.V.R.

Marriages

CROSS—WHEELER.—On January 11th, 1943, at St. Botolph's Church, Shenley, Fl.-Officer William George Cross, elder son of Mr. and Mrs. W. M. Cross, of Elstree, Herts, to Mary Lucy, elder daughter of the Rev. and Mrs. S. M. Wheeler, of Shenley, Herts.

GOODRIDGE—BEAZLEY. — On January 16th, 1943, at Plympton, South Devon, Surg.-Lieut. Derek L. Goodridge (D.), R.N., to Joan Beazley.

MARKS—DUTCH.—On January 31st, 1943, at the New West End Synagogue, W.2, Morton G. Marks to Eleanor Dutch.

Births

CHAPPLE.—On December 17th, 1942, to Sheila (née Hobbs), wife of Captain H. A. L. (Archie) Chapple, the Wiltshire Regiment—a daughter (Sarah Elizabeth).

HALLAM.—On January 15th, 1943, at Lansdowne Nursing Home, Blundellsands, Liverpool, to Marny (née Weaver), wife of John Wemyss Hallam, L.R.C.P., M.R.C.S., L.D.S. (Eng.)—a son and a daughter.

Deaths

GREENWOOD.—On January 14th, 1943, at Base Hospital, Cairo, Captain Kenneth H. Greenwood, L.D.S., R.C.S., aged thirty-eight.

HOPSON.—On January 26th, 1943, at Pinegrove, Crowthorne, Bucks, Montagu Frank Hopson, beloved husband of Eva K. Hopson.

PEARSON.—On December 29th, 1942, at Hamilton, Buckingham, George Bruce Pearson, L.R.C.P., L.R.C.S.

TEBB.—On January 20th, 1943,, suddenly, in York, A. E. Tebb, M.D. (Lond.), M.R.C.S., L.R.C.P., D.P.H., aged seventy-nine.

EDS. { P.F.E.B. J.O.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVII. No. 1424 *20th February, 1943* *Ninepence*

PASSIM

HEALTH education, especially with reference to the health of the factory worker, is a subject attracting much attention at present. Ill-health is one of the most important causes of loss of worker's time, and therefore of production, and whatever their attitude in peace-time, the authorities cannot now afford to neglect this problem. As evidence of this we have received recently several booklets which have been produced by the Central Council for Health Education, in collaboration with the Ministry of Health. These, which are produced in an attractive format calculated to attract attention, cover a wide range of subjects. One is urged, " Be kind to your stomach," including advice to visit the doctor if one has indigestion, rather than fly to some patent stomach powder. One is advised on " Care of the feet," on how to make the most of rest intervals to secure the utmost relaxation, and on the general principles of hygiene, in particular factory hygiene with emphasis on the need for care in washing to avoid dematitis, and allied subjects. And all in a manner which avoids the twin pitfalls of overtechnicality and a patronising simplicity.

In addition, we have received from the Ministry of Health itself three further pamphlets produced by the Council for the anti-venereal disease campaign. One deals with " What are the venereal diseases ? " ; the other two are what are commonly known as " sex talks " for men and women respectively. The ground here is distinctly controversial, and some may doubt if the printed word is as effective as the spoken in these matters, but the authors of these pamphlets have certainly achieved a sensible attitude in their writing.

But if the authorities are showing the general public to the doctor's front door, what efforts are the doctors and, as particularly concerns us, the medical students, making to be ready to receive them ? We have our lectures on public health, courses on venereal diseases, and so on, and no one will deny that they are very good, as far as they go. But more is going to be needed if a full understanding of the implications is to be achieved. A recognition of this is implicit in the recent appointment of Professor Ryle to the Oxford Chair of Social Medicine, and, though we as yet have no such chair, we can certainly start to consider the problem. We have already a basis to build on in the Physical Society. Some of the more recent entrants to the clinical period may not have heard of this, as it has recently been noticeable rather by its lack of activity than otherwise, but not so very far in the past, interesting meetings were held at Guy's and Farnborough. At these the main activity has been the discussion of cases in the wards, but it is surely within the bounds of its province to extend this to the social implications of these illnesses. Anyhow, the presence in the Hospital of an active society is itself a stimulus to discussion and a centre around which further developments can be organised. It is hoped that a revival of meetings will take place shortly.

While on the subject of discussion and the dissemination of knowledge, the Editors would like to point out that they are always willing to publish in the *Gazette* descriptions of cases of interest in the wards. To write up a case for this purpose is useful practice and the general interest which is aroused often leads to new suggestions being put forward which are of value both to the patient and to the student. The registrars are always willing to help on these occasions, so next time you have an interesting case, ask your registrar about it and let us have a summary.

ST. BARTHOLOMEW'S, St. Thomas's, St. Mary's—so why not complete the sequence ? The following address appeared on the envelope recently received here :—The Doctor

in Charge of the Clinic Department, St. Guy's Hospital, London Bridge. We have risen to new—and who shall say undeserved ?—heights.

WE regret to announce the death of two Guy's men—one a dental student, the other newly qualified in medicine.

John Whatley entered Guy's in October, 1938, and joined up in December, 1939, in the Oxfordshire and Buckinghamshire Light Infantry, serving with No. 4 Commando. He was killed in action in the raid on Dieppe on August 19th, 1942.

Herbert Wilford Bunn entered Guy's in 1934, qualified M.R.C.S., L.R.C.P. in April, 1942, and was appointed House Surgeon at St. John's, Lewisham. We have heard from his father that the boat on which he was sailing to South Africa has been lost. Any photographs of his son or any further information could be sent on to Mr. J. H. Bunn by the Editors.

IN this issue of the *Gazette* there appears a short article, entitled " Jacobsoniana," which we hope will be of interest and amusement to both present students at Guy's and old " Pom " dressers. The present generation at Guy's may not know who " Pom " was. He was Walter Hamilton Acland Jacobson, M.A., M.Ch. (Oxon), F.R.C.S., " Assistant Surgeon to this Hospital for twenty-four years and never had a case I can call my own "—this in reply to a dresser who, when " Pom " asked : " Whose case is this ? " answered " Mine, sir ! "

These few stories, written by one of the old " Pom " dressers may stimulate others to send in their recollections of a man who was " the strangest mixture of courtesy and rudeness, wisdom and judgment, real wit and mere play-acting that ever I met, but, above all, he had the art of attracting us and we all struggled to serve on his firm and kiss the rod."

THE Index for Volume LVI (1942) is now ready for distribution and may be obtained free of charge on application to The Manager, *Gazette* Office, Guy's Hospital.

Subscribers who have not already sent their subscription to the *Gazette* (12*s*. 6*d*. per annum, post free) are reminded that it is now due.

ALL Guy's people will be very sorry to hear that Mike Mullins has decided, in company with many fellow South Africans, to return home. Nowhere will he be missed more than amongst the players and followers of Rugby football. Surely one of the best forwards at Guy's in recent years, his value to the Guy's side was immense, both on the field (as player and as leader) and off the field. It was, indeed, a great pity that he was not here in the days of peace, as International honours might so easily have come his way. As it was, his ability was recognised by his playing for the Barbarians for the last two seasons (incidentally thus carrying on a family tradition) by his being captain of the United Hospitals and by his captaining a representative London side this season.

But it is not only on the Rugger field he will be missed, but also in the many spheres of life at Guy's (and the bases !) in which he, and his wife, took such an active part.

All their friends will, I am sure, join in wishing them both a safe journey home and all the best of luck in the future.

A MONTH ago we published a letter from a Prisoners of War camp in Germany, and we put forward an appeal for old Rugger clothes to send to the camp. Very little equipment has so far reached this office, and we hope that it is merely because the clothes are being washed first before being sent in. We have to thank Mr. Layton, Mr. Brock, Dr. Ellis Brown, Dr. R. G. Ticehurst, H. B. F. Ordish and the Staff of the Light Department for starting our small collection.

Obituary

MONTAGU F. HOPSON, L.D.S., R.C.S. (Eng.).

ON Tuesday, January 26th, 1943, there passed away one more of those distinguished men who have enhanced the reputation of Guy's, both by their services to the Hospital and by their life-work in the world.

Montagu Francis Hopson was born at Newbury on December 5th, 1869. He was educated at St. Bartholomew's Grammar School, and in due time rose to the position of head boy of the school. He then became the articled pupil of Mr. Walter Toms, and on completion of his appointed period of instruction was confronted by the problem of choosing a Dental School at which to carry on his studies.

On December 12th, 1888, the Court of Committees presented a Memorandum to the Governors of Guy's Guy's Hospital, recommending the establishment of a Dental School. The Governors decided to act upon the recommendation, and one month afterwards Montagu Hopson made an application to be admitted as a student, appreciating the advantage of a Dental School in such close association with the world-famous Guy's Hospital and Medical School.

The Dean accepted his application and Hopson became the first student of the Dental School of Guy's Hospital, and the connection thus begun lasted until his death more than fifty years afterwards. In the Bicentenary Number of the *Guy's Hospital Gazette* is a picture, reproduced from the *Daily Graphic* of October 14th, 1892, showing the old conservation room in which he commenced his clinical work, and one of the figures in the drawing is Montagu Hopson.

His career from the first was a brilliant one, and his work was soon recognised to be of the first order. On his qualification in May, 1891, he became House Surgeon. This was followed in 1893 by his appointment to the Staff.

Hopson was a born orator, and his lectures were popular and largely attended. He first lectured as assistant to Mr. Groves at that time lecturer on Dental Metallurgy, and, on the retirement of Mr. Maggs, he was appointed lecturer in Dental Anatomy and Physiology, a subject which to many would have been but dry bones, but which Hopson could clothe with flesh and infuse with the breath of life and of Nature.

In 1919 Mr. Wynne Rouw retired from the active Staff and Hopson became the head of the School. His practical wisdom, understanding of affairs, tact and invariable goodwill and kindly consideration to all, combined to make his leadership of the School an outstanding success, and he is, and always will be, remembered with gratitude and devotion by the vast multitude of students who passed through his hands. "Popularity" seems to the writer an inadequate and superficial word to apply to the feeling we all had for our Head, although not easily analysable, it was something more intimate and more infused with personal regard and admiration.

To Hopson largely belongs the credit of the foundation of the Dental Society, the first meeting of which the writer well remembers. The Society is of the greatest value to the School, and through the years of its existence its annual dinner has become an important institution, not only to present students, but also, and perhaps more especially to old students, to whom it is a welcome opportunity of meeting old friends.

Every year hundreds of old and present members of the Society flock to the dinner, and the ovation Hopson always received will never be forgotten by those who heard it.

On his retirement from the active Staff he was immediately appointed Consulting Dental Surgeon of the Hospital and a Governor of the Medical and Dental Schools.

In 1893 Hopson married Miss Eva Thatcher, and through all the years that followed Mrs. Hopson was a true partner and helpmeet in all his work. She took an immense interest in the Hospital, knew names and even nicknames of students, and was as popular with them as was Hopson himself. Their only son, Guy, entered the Dental School, but, on the outbreak of the 1914 war, joined the fighting forces and, when peace came, decided to adopt the military profession as his life work, and has now risen to

the rank of Lieut.-Colonel in the R.A.S.C. Colonel and Mrs. Hopson and their three children are frequent and welcome visitors at the grandparent's house at Crowthorne.

One who has known Hopson for fifty years and had the privilege of calling him friend, may be pardoned if he thinks of hospital and personal matters first, but Hopson has done much and good work in the great world outside.

He started practice in partnership with Mr. Harold Murray, at that time lecturer on Operative Dental Surgery at Guy's, and afterwards moved to Harley Street. In 1913 he was appointed Examiner by the Royal College of Surgeons; later on by the Universities of London, Birmingham and Sheffield; and by the authorities of the Naval Dental Service. He was also made Consulting Dental Surgeon to the Royal Army Medical Corps with title of Professor, which, however, with his usual modesty, he never used.

Hopson rendered great services to the British Dental Association over a period of many years as Treasurer, President, Secretary and Virtual Manager of the Benevolent Fund, and in many other ways. In 1928 he was made a perpetual Vice-President. During his year of office as President of the Association a number of friends combined together to present Hopson with his portrait. The number anxious to participate was so great that the artist, Mr. Frank O. Salisbury, was commissioned to paint two portraits, and to-day one of these is at Guy's and the other at the headquarters of the Association.

Two works of public importance owed much to Hopson's ability and energy. In conjunction with Sir Norman Bennett he prepared and presented the case against unregistered practice with such skill that the Government was moved to promote and pass into law the Act of 1921. He also played no small part in the activities that resulted in the formation of the Army Dental Corps.

Lack of space forbids more than the mention of other offices such as Secretary of the old Odontological Society; President of the Odontological Section of the Royal Society of Medicine; President of the British Society for the Study of Orthodontics, etc. Besides lectures and addresses his published writings have been many and various. He was a keen entomologist and a fellow of the Royal Entomological and Linnean Societies. He himself had a magnificent collection of lepidoptera, including one of the very few known specimens of the extinct large copper butterfly. On his retirement Mr. and Mrs. Hopson went to live at their house at Crowthorne, with its beautiful garden surrounded by the pinewoods. Here he spent the remainder of his days in happiness and quiet, and there was always a welcome at "Pinegrove" for friends new and old. Hopson loved his garden and liked to watch his favourite lepidoptera, amongst them the lovely *Gonepteryx rhamni* flitting round the bush of buckthorn specially kept up for its benefit.

It is comforting to know that his end was painless. In the years of his retirement he was always his old genial self, and was spared, as the writer hopes he may himself be spared, the tragedy of having to live through to the end the chill grey years of Shakespeare's "seventh stage of man."

"The dewdrop slips into the shining sea," Hopson is at rest, but his work is not resting; it goes on bearing fruit, and is part of the heritage of generations of men yet to come.

An address given in the Chapel of Guy's Hospital on Tuesday, February 2nd, 1943.

I SPEAK to the memory of Montagu Hopson—a man greatly beloved. To-day we think of Mrs. Hopson in her illness and sorrow and of his son. Tennyson has written—

> "As when a painter, poring on a face,
> Divinely thro' all hindrance finds the man
> Behind it, and so paints him that his face,
> The shape and colour of a mind and life,
> Lives for his children, ever at its best
> And fullest; . . . ."

Many of us are, professionally, Hopson's children. The picture comes to our minds. The spare figure of medium height; the head with its iron-grey hair, nobly poised; the face with its expressive eyes and the eyebrow raised in quick appreciation or in admonition. In the year 1793 systematic courses in dental surgery were commenced

in this Hospital; nearly a century later the Governors decided to found a Dental School. It was Hopson's pride, and it is our great glory, that he was the first to enter its doors. There exists a photograph of the dental students of that day, grouped in front of the alcove from old London Bridge, Victorian students, with high stiff collars, many of them with heavy moustaches and some "beard'd like the pard." In the centre sits the House Surgeon, clean shaven, upright, intelligent, Monty Hopson. Such a one naturally became a teacher; his patience, his clearness, his ready sympathy made him pre-eminent in his vocation. With his wide reading and vast knowledge of men and of affairs, he saw that such a specialty as dental surgery might become too constricted, that it might even make men narrow. So he chose, as his particular subject, Special Anatomy, in its broad zoological sense. His instruction culminated in the book, "Apes to Modern Man," which contained all the information published up to that time. His lectures on "Neuralgia" and other clinical subjects were of great benefit to those who heard them. Upon the nomination of his friend, John Dunn, he was elected a Member of the Dental Board of Examiners. The President and Council of the Royal College of Surgeons, from time to time, in their wisdom elect an L.D.S. who is not the holder of any other medical qualification. Of such they demand high technical ability, deep scientific knowledge, and the ability to understand men. All agree that Hopson excelled in this high and responsible office. In his work for the profession as a whole he sacrificed both leisure and money, he held the highest offices in the British Dental Association and at the Royal Society of Medicine. One of our number has said that circumstances are like clouds gathering and bursting upon us. So it was with Hopson, in his retirement he had to face illness and difficulty. In this he was greatly sustained by the companionship of his wife and by the visits of his friends, who brought that personal friendship which his kindly soul demanded. There was no out-patient so poor or so weak but they received the fullest care and consideration from Hopson; no patient so rich or so influential that they dared to disregard his instructions; and so as a practitioner he was greatly respected and sought for. And so to-day, in this sacred place and reverently, we thank God for the life of Montagu Hopson.

Sector News

Pembury Letter

IT is a long time since there has been a letter from here, so that it is hopeless to chronicle all the events that have happened during the silent interval. This lack of news is not due to the fact that nothing ever happens down here; a great deal, both medical and social, occurs. The Superintendent of the Hospital, Dr. Grasby, has just held the first of a series of smoking concerts for the male staff. At these concerts the guests have to be their own entertainers. If they do not entertain the rest they have to place a forfeit in the Red Cross Prisoners of War Collection. By these means it is hoped that many of our more gifted entertainers will be able to find scope for their talents. Already many amusing stories have been exchanged, but there is no need for the Stock Exchange to fear our rivalry in this respect—yet!

A number of artistic notices, with pictures of naked children armed with bows and arrows, have announced the fact that there is to be a St. Valentine's dance. We welcome St. Valentine and his dance, but we are not yet in a position to relate any good stories connected with this celebration.

H. B. F. O.

Reviews

Hale-White's Materia Medica. By A. H. DOUTHWAITE. Published by Messrs. J. and A. Churchill. *Price* 14*s.*

THIS is the twenty-fifth edition of this useful book which must be a record for any medical publication and is a certain proof of its popularity and usefulness. It is full of the most important information, and anybody who still retains his horror of this subject from his student days will be surprised to find that a great number of chapters make most interesting reading. Important groups of therapeutic substances as the barbiturates, sulphonamides and vitamins are discussed extremely well and that difficult subject "endocrinology" is clearly presented. A list of drugs not to be used in war-time is found at the end. This book should be extremely useful to those taking their Finals and to practitioners for reference.

W. G. T.

Notes on Dental Conservation

By A. R. F. THOMPSON, M.R.C.S., L.R.C.P., B.D.S.,

IN the course of practising and teaching dentistry one is repeatedly mortified by the technical errors in one's work and not altogether discouraged by the faults of others. One of the most difficult things is to produce consistently good inlays in a reasonable time and, therefore, I propose to consider certain aspects of gold inlay techniques in the first part of this paper.

Some Observations on the Gold Inlay.—(1) Having in the past been interested in the dimensional change aspect of inlay construction it is proper that I should record the view that, using modern investment materials, the discrepancies in practice which arise out of physical change in the materials used are completely overshadowed by the errors which can and do arise through the difficulty, and in some cases the impossibility, of producing a pattern of the correct shape. I am aware that from some theoretical aspects the indirect method produces greater accuracy than the direct method, but this and similar considerations are outclassed in importance by the question of obtaining a wax pattern which, disregarding the above-mentioned minor physical changes, will come out of and, if need be, go back into its cavity and maintain its fit. On this occasion I am concerned simply with the more gross aspects of misfit which, unfortunately, are reflected particularly to the cervical margins of Class II inlays. The following are some such considerations :—

(1) In either direct or indirect methods particular care must be taken to maintain pressure on the wax when it is cooling in order to compensate for the change of state contraction which occurs when the material is cooling from its semi-molten to its solid state. If such care is not taken small voids occur between wax and cavity. Because the cervical approximal part is usually the furthest part and is also the part of least bulk, these voids most commonly occur in this situation. When the casting comes to be cemented and its edge ground in, the slightest amount of gold removed will reveal a cement line, and, as is common knowledge, the more vigorous the efforts to draw the gold over this discrepancy, the greater it becomes. In the indirect method these voids can be eliminated by preliminary warming of the die in conjunction with holding the wax in place under the pressure of the first finger and thumb of both hands simultaneously. Thus the whole wax surface, even of an M.O.D., can be constrained under pressure. In the direct method the same effect can be produced by use of the Bonnallie matrix retainer or similar type. The necessary enclosing pressure can be obtained if the patient closes firmly at the same time as the band is continually tightened against tooth and wax.

(2) In the direct method it will be frequently found that the force used to trim the wax moves the wax in the cavity and, as it were "shunts" it about. Then following the usual procedure, and assuming the error has not been noticed, the edges are warped to place by hot wet cotton-wool. The result is the production of hidden voids similar to those described in (1) above, but in this case the error involves the occlusal surface principally. To avoid these errors any appreciable mass of wax should be removed with hot instruments and, in addition, a certain amount of the pattern may be stuck down temporarily to the tooth surface beyond the cavity until such time as it becomes necessary to deal with that particular portion of the edge. An aid to carving and to detection of this type of error is to keep the area dry in the customary fashion. An indispensable aid to contouring because of the darkness of the wax is an auxilliary light, preferably both headlight and Cameron type held by an assistant.

(3) In an even more elementary discussion on the gold inlay much could be said about the main cause of difficulty, namely, unsatisfactory cavity preparation. Here only two aspects of this fundamental consideration will be treated. *Firstly*, some Class II cavities present difficulty because of their extreme approximal depth. This is partly caused by the inaccessability of the depth of the cavity and partly because of the degree of undercut encountered at or below the tooth neck. Neither the direct nor the indirect methods provide any satisfactory solution, and in these cases it is better to consider a compound restoration with amalgam in the cervical part and gold overlaying it and restoring the occlusal and part of the approximal. From experience in teaching this modification I must make the point that this method is not to be considered in the same category as correcting a bad inlay by attempting to pack soft amalgam into a cervical discrepancy after the inlay has been set in place. The pro-

cedure is to pack amalgam into the deep approximal part of the cavity which has been rendered or left undercut, using a suitable matrix retainer. At a subsequent visit the inlay cavity is cut, with a false approximal cervical margin at the upper surface of the amalgam. The resultant restoration has all the advantages of the inlay such as resistance to edge deterioration and good contact characteristics. The amalgam at the cervix is not subjected to mechanical injury and in that situation is as serviceable as gold. *Secondly*, certain types of cavity present inordinate complications. One of the commonest is the possession of pinnacles of tooth substance. Such a pinnacle will occur when a mesio occlusal molar cavity is extended over the lingual or buccal fissures and thus leaves the anterior cusps isolated. These pinnacles are in any case a source of weakness because they become denatured owing to the isolation of their dentinal tubules from the pulp. Apart from this reason they are better removed, as they are an unnecessary complication of the area and type of surface to be fitted. Moreover, when the casting is completed the pinnacles are represented by deep pockets which frequently collect gold bubbles owing to the difficulty of investing. An alternative viewpoint of this suggestion is to keep the cavity outline shorter rather than longer, and the form of the cavity as simple as conditions will allow.

(4) It now comes to consider the choice of direct or indirect methods, and at the outset I would state that both are indispensable if uniformly satisfactory different types of inlay are to be made. It will be convenient to discuss the various inlay types in order :—

(*a*) The small Class II inlays in premolars, not extending far below the contact point :—These are best treated by the indirect method in conjunction with the slice preparation. By these means no more tooth is sacrificed and, in fact, fewer dentinal tubules are cut to produce extension for prevention than the conventional box type. Moreover, small masses of wax are controlled with difficulty directly, and are particularly prone to the " shunting " difficulty.

(*b*) Larger Class II inlays, and especially those in molars not extending below the amelo-cemental junction :—Because molars are flatter mesially and distally in the main than premolars, and because these cavities offer a fair volume for the wax, these types are better treated directly. The slice preparation which is almost essential if it is intended to follow with the indirect method is frequently wasteful of tooth substance and still leaves a seriously undercut area just outside the cervical buccal and lingual approximal points. This undercut area frequently causes difficulty in withdrawing even a very well-fitted ring as it tends to break the vital part of the impression's edge. The slice preparation is more useful when very large amounts can be sliced off so that the tooth looks like a truncated pyramid from the side. This ought only to be done when there has been much destruction by caries. If the slice can be extended partly on the labial and lingual surfaces so much the better. Where the cavity involves more than three surfaces the indirect method is superior because the difficulty of carving the wax directly is too great.

(*c*) Class I cavities are more simply dealt with indirectly than directly if the laboratory work can be deputed.

To sum up it could generally be maintained that extremely simple or small inlays and extremely complicated and large inlays are better treated indirectly, while inlays of intermediate size and complexity are better treated directly.

An Unusual Type of Bridge.—Two things are noticeable in hospital practice. Firstly, the extraordinary amount of force that is necessary to remove some teeth. Surely we are savers of teeth, not destroyers ; and if a tooth is so firm that it requires considerable force for its removal would it not be better to let it remain and consider conservative measures for any gaps, rather than to make the mouth one big gap ? Secondly, how frequently is a single missing tooth replaced by a denture, thus causing parodontal disease ? Arising out of these is a need for the more frequent use of bridges. In this connection a type of bridge has been in use for very many years which seems to have escaped general notice and yet deserves attention. For want of a better name it could be called a spring cantilever bridge, in which the pontic is connected to the single abutment tooth by a thick flattened platinum wire, usually A or B size. This connecting wire should be long enough, say at least one inch, to permit the pontic to move freely on pressure. It may, and preferably does, bypass one or, perhaps, even two teeth, and is contoured closely against the palate or lower ligual alveolus as the case may be.

To those unaccustomed to this bridge the description given will suggest a host of doubts and reservations, but they can be assured that the disadvantages reside principally in their minds. The obvious objections are—firstly, that the wire will be resented and will be a dirt trap ; and, secondly, that no pressure can be exerted for mastication on the pontic. To the first objection it can be said that in my experience no patient has complained of obstruction to the tongue by the wire ; in fact, when specifically questioned on this point they have reported that the wire was almost undetectable in a few hours. To the second objection it could be maintained that it should be possible to avoid incising on the pontic, but, in fact, patients can and do incise without discomfort. Presumably this is made possible partly by the resistance of the wire itself and partly by the area of contact of wire and pontic with the gum being sufficiently large.

Having dealt with the theoretical disadvantages we can discuss the advantages and the specific uses :—

Because the pontic is, in effect, loosely connected to the abutment little stress can be communicated, and there one of the chief causes of failure of bridges, namely, loosening of abutment teeth, eliminated. Further, because there is only one abutment there is only half the potentiality for loss on this account. The second commonest cause of failure of bridges is caries of the abutments due to obstruction, particularly of the contact points and consequent food collection. Here, again, the spring bridge offers advantages because there is no obstruction of contacts, the wire usually being soldered to the lingual aspect of the abutment. In addition to the general advantage of conservation of abutments the bridge has unique advantages in certain cases. Such cases are :—

(1) Where an upper lateral is lost and the canine and central teeth are caries free and unfilled and the premolar or molars are filled. This is by no means a rare combination of circumstances, and is one in which the operator is spared the necessity of having to cut a sound tooth, and can instead utilise the already treated premolar.

(2) When a single incisor tooth is lost and the adjacent teeth are unsuitable as abutments because of either apical abnormality or parodontal disease.

(3) Where a tooth is missing among others which are spaced. With the usual method of construction the connecting link would be revealed or the pontic would have to be unnaturally wide.

4. Where a lower central incisor is missing, because the peculiar convergence of the lower incisors towards their narrow necks makes the construction of the usual abutments difficult or unæsthetic.

The method of construction is as follows :—The abutment can be of any type that provides gold lingually. It will thus be typically a pinlay or three-quarter crown, but any combination of pin, groove, and re-entrance can be used—for example, a lower canine could have a mesial groove, a lingual pin and a distal re-entrance to the labial. When the abutment piece is satisfactorily fitted a plaster impression should be taken over all and a Mellotte's metal model poured. It is advisable to leave the sprue in place at this stage, and therefore it should have been placed in a position which is clear of the occlusion. In the case of pinlays and other retentive preparations it is wise to obscure most of the pins or recesses, as the case may be, with a minute quantity of mouldine before pouring the Mellotte's metal. This will enable the abutment to be removed easily from the model. The course of the spring should now be mapped out on the palate and should run round and between, rather than over, the rugæ. The area of palate enclosed by the sweep of the spring may conveniently be about that of a sixpence. Having decided the position of the spring the model should be grooved about half the depth of a No. 6 rose-head bur, so that the wire will subsequently lie firmly against the mouth, and not leave a space between wire and mucous membrane. If at first the wire appears to bear too heavily against the tissues, no fear that ulceration will result need be considered. A small piece of lead foil, or, preferably, X-ray film metal, should now be lightly conformed to the groove on the model and cut out to that shape. When flattened this " query " shaped template is needed as a gauge to apply " edge bend " on the wire. The wire of A or B size in platinised gold as demanded by its length or required strength is flattened and bent first against its edge to conform to the template ; and, secondly, against its flat surface down into the groove on the model. The ends of the wire are fitted closely to the abutment and pontic respectively. In the case of the abutment the attachment should be as close to the cervical edge as is

consistent with attaching it to a strong part of the pinlay. This type of bridge construction lends itself particularly to the use of acrylic pontics because that end of the wire spring is merely bent up into the pontic space and roughened for subsequent attachment of the acrylic material.

When the bridge is completed there remains the possibility of slight adjustment if it is found that the pontic does not register accurately with its correct position. In practice it will be found wise not to presume far on this latitude.

"Jacobsoniana"

IN a corner of the little churchyard of Ewhurst, in Kent, there is a grave—nameless, at his own request—where lie the mortal remains of Walter Hamilton Acland Jacobson, M.A., M.Ch., F.R.C.S., one-time surgeon to Guy's Hospital and known to generations of Guy's men as "Pom." Few, if any, members of the Guy's staff ever had a greater attraction for or received greater loyalty from their "firms" than he. One of the most kind-hearted, rudest, irritable, patient, autocratic and humble, with a humility so often protested as to raise doubts in the minds of some whether it was real or merely a pose. Possibly it may have partaken of both; but a great scholar and a great gentleman.

Probably more stories have been told about him than about any other Guy's man—stories illustrating his quaint conceits, academic snobbery, gruff kindness, lightning repartee and real sense of humour. Rather under middle height, dapper and looking like a bishop in mufti (he used to speak of "my mother, the wife of my father, the late Lord Bishop of Chester"), he wore remarkable collars of the "Gladstone" type and shirts specially made with the collar-stud so low that his suprasternal notch was clearly visible. His smile was benignly episcopal, but his thin-lipped, determined mouth could rap out biting rebukes to students and patients alike, often followed almost immediately by some kindly act or remark. He was a painstaking teacher, and scarcely a day passes without the writer having to thank him for something learned while on his firm.

It seems a pity that the myriads of characteristic "Pom" stories should be forgotten. Many of his old dressers—a high percentage of whom have had distinguished careers—are still with us and between them they could compile an interesting record of Jacobsoniana. The story goes that when it was his turn to be elected to the full Staff (he married late in life) he said, "No! Mr. Golding-Bird is a married man. Let him go first!" Thus it came about that when the writer was on his firm he had been assistant-surgeon for twenty-two years—a fact which we were not allowed to forget. Going round the wards he would ask his dressers, "Whose case is this?" "Mine, sir," one would say. "Really!" Pom would reply. "I've been assistant-surgeon here for twenty-two years and never had a case I could call my own!" He would repeat the question at another bed and I remember a man answering, "I suppose this is yours, sir." "Don't quibble, sir; don't quibble!" snapped Pom.

Pom used to *walk* from his house in Great Cumberland Place to Guy's to keep appointments with old patients at the Hospital, often on Saturday afternoons or Sundays. Many of these were stricture cases (*cf.* Jacobson's "Diseases of the Male Organs of Generation") on whom he would pass bougies. A very tall flaxen-haired staff-nurse, new to the ward and to Pom's peculiarities, saw a screen at the end of Naaman, which she thought had been left out by a ward-clerk. She stalked down the ward with a gait which had earned for her the name of "The War Horse," and from her six feet of height looked over the screen, on the other side of which Pom was passing a bougie. Pom looked up over his spectacles at the same time and said just two words, "Immoral Giraffe!"—by which name she was ever afterwards known.

Pom (in Sammy Ward): "Bring me a yard of bandage, Sister, please."
Sister goes away and returns with a piece about eighteen inches long.
Pom (surveying bandage): "I asked you for a *yard* of bandage."
Sister goes away and returns with a piece about six feet long, held at arm's length.
Pom (again surveying bandage and, over his glasses, the Sister): "I asked you for a yard of bandage, *not* for a yard of face!"

"Mr. X—— (his house surgeon) I wonder whether you will help me to-morrow, Sunday, in the pathological laboratory to cut some sections for my class?" "Yes, sir; I don't mind." "I see, sir," said Pom, "that means you'd rather not. Let me see, Mr. X——; I believe your father is a Clerk in Holy Orders?" "Yes, sir, he is." "How very sad," said Pom. "How do you mean, sir—sad?" "How sad it is that the son of a High Dignitary of the Church should tempt the son of a low one to work on Sunday."

In the old anatomical theatre which stood on the site of Nuffield House, certain students used to sit in the top row near the door, so that they could bolt after the janitor had taken their names. One of these, popularly known as "Fatty," was one of the regular "bolters." Pom came into the theatre and, before beginning his lecture, looked round over the top of his spectacles and saw "Fatty" in the top row near the door. "Ah! there you are, Mr. X——, in your usual place. The scum always rises to the top!" "Yes, sir," said Fatty, "and the dregs always fall to the bottom"—and walked out. There was a roar of laughter in which Pom joined.

Hospital Information, etc.

Pass List

CONJOINT
FINAL EXAMINATION.
January, 1943.

Medicine.

*P. L. Blaxter	*H. B. F. Ordish
P. F. E. Brown	*R. T. Parkin
*J. D. Buxton	J. A. Nissim
*A. H. Drewitt	*J. P. I. Rose
P. Hopkins	*W. H. Trethowan
*R. I. McCallum	S. M. Vine
*I. S. MacLeod	*I. R. Waters
*F. S. Mellows	B. H. Wilshere
J. K. Ogden	K. L. Wilson
A. J. P. Oldham	

Midwifery.

M. M. Figgis	J. W. Robb
M. A. Filose	K. H. L. Scougall
W. Fox	W. H. Smith
C. W. L. Jeanes	J. R. Trounce
P. G. Large	B. H. Wilshire
J. K. Morgan	

Surgery.

R. A. J. Baily	*I. S. MacLeod
*J. F. Baker	M. G. Marks
*T. M. Ball	I. L. McKelvie
M. V. Doherty	R. L. Ray
*G. M. Evans	*J. Ronchetti
W. Fox	K. H. L. Scougall
C. O. Fung-Kee-Fung	R. S. Smith
G. Hildick-Smith	J. D. Trethowan
P. Hopkins	H. Whitworth
*W. H. Humphreys	

Pathology.

J. K. Argo	R. G. Lomax
*J. F. Baker	A. J. P. Oldham
A. S. Carruthers	J. W. Robb
M. J. Cutler	*I. R. Waters
J. M. Fabricius	O. H. E. Williams
C. W. L. Jeanes	K. L. Wilson
H. J. Lewis	R. M. Woodside
*W. J. Lewis	

* Have completed the examination.

ROYAL COLLEGE OF PHYSICIANS,
M.R.C.P.
January, 1943.
Wilfred Fine

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
January, 1943.

Surgery.—*R. A. Bush, J. M. Thomas.

Medicine, Pathology and Forensic Medicine—P. L. G. Cole.

Midwifery.—R. K. Haslam.

* Has completed the examination.

Prisoner of War

Ft.-Lieut. Clifford Maxwell Beales (D.), R.A.F., in Java; previously reported missing.

Missing

We regret to report that Captain Ed. J. A. Needham, R.A.M.C., and Dr. Herbert W. Bunn are missing and believed lost at sea (December, 1942).

Change of Address

J. E. Darlow, Le Chalet, Wyberton, Boston, Lincs.

Births

OCKLESHAW.—On February 5th, 1943, at Guy's Hospital, to Annabel (née Knott), wife of Lieut. J. M. Ockleshaw, R.A.—a daughter (Janet Linda).

Deaths

HOWE.—On February 6th, 1943, at Elmcroft, Holden Avenue, Woodside Park, George Hubert Howe, L.D.S., R.C.S. (Eng.).

EDS. { P.F.E.B. / J.O.L.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE study of pathology is and must be the foundation on which all medicine is built, and nowhere is that fact more obvious than in the teaching of medicine. The Medical School Council have decided that all those entering for the Conjoint finals for the first time should start with Part I—namely, Pathology. The Conjoint Board had relaxed its regulation about the order in which the finals could be taken about the same time that the length of the clinical period was reduced for war-time purposes, but the task of passing in the clinical subjects without an adequate knowledge of Pathology was often the stumbling block to a smooth passage through the finals. Anyway the subjects attempted depended very largely on the appointments just previously held, and one reason why many did not take Pathology first in recent years was the fact that they came to the end of their twenty-four months' clinical period, having been primed for the last few months with Obstetrics and Gynæcology and eager to take a subject which they had been living with so lately. Pathology, on the other hand, assimilated slowly during two years, needed a little time to consolidate—and there again the question of where best to consolidate it often arose. The scattering of the students through the Sector and the inauguration of teaching at the base hospitals were great upheavals at these places, but finally all things settled down. Pathological material was collected, and with a small nucleus borrowed from the Gordon Museum, small teaching collections were formed at Farnborough and Pembury. These collections, especially the one at Farnborough, are of the greatest use both for the revision of Pathology and for the systematic instructions. The system of appointments have also changed slightly now, so that the first six months are run together into three—pre-clinical and surgical ward-clerk. This means that on arriving at twenty-four months the appointments so work that there is a very good opportunity for that consolidation of Pathology that is so essential. Systematic lectures will still be the foundation, at Guy's and Farnborough, and when needing that little bit of revision, the collections at Farnborough or Pembury and the newly-labled "teaching collection" in the Gordon Museum should supply all that is necessary.

MAY we make a plea for what remains of the Park? The rude and rushed have trampled roughshod over the grass of the Park for too long, and now that the chains are up again surrounding what green is left, we hope that some green will show itself this summer and not be trampled down into numerous muddy paths.

WE used to think of the base hospitals as branches of the Alma Mater; perhaps we are mistaken. Recently a woman attending the Out-patient Department at Farnborough was told to attend Mr. X.'s Out-patients at Guy's, whereupon she replied inquiringly: "Is that the London Bridge branch of your hospital?"

I had become a pluralist of the most abandoned sort, and at the end of ten years it was difficult to say what I did profess: I felt like the man in Alcibiades, II, to whom are applied the words of the poet—

"Fully many a thing he knew;
But knew them all badly."

Sir William Osler.

BIRTHS AND DEATHS REGISTRATION ACTS, 1836 TO 1929.

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths direct.

Registrar to enter No. of Death Entry. .....

Name of Deceased .....

Date of Death as stated by me.....day of.....19..... Age as stated to me.....

Place of Death.....

Last seen-alive by me } ..... day of .....19..... { Seen* / Not seen* } after death by me.

The certified cause of death { has* / has not* } been confirmed by Post-mortem.

CAUSE OF DEATH.

I.

Immediate cause† .. .. *a*.....

Morbid conditions, if any, giving rise to immediate cause (stated in order proceeding backwards from immediate cause) .. *due to* *b*..... *due to* *c*.....

II.

Other morbid conditions (if important) contributing to death but not related to immediate cause .....

.....

I hereby certify that I was in medical attendance during the above named Deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature..... *Qualifications as registered by Medical Council* .....

Residence ..... *Date* .....

* Strike out whichever is inapplicable.

† This does not mean the mode of dying, such as *e.g.*, heart failure, asphyxia, asthenia, etc.; it means the disease, injury or complication which caused death.

DECEASED'S IDENTITY CARD AND RATION BOOK MUST BE DELIVERED TO THE REGISTRAR.

NOTICE TO INFORMANT.

I hereby give notice that I have, this day, signed a Medical Certificate of the Cause of Death of.....

.....deceased

Signature .....

Date.....

This Notice must be given by the Certifying Medical Practitioner to the person who is qualified and liable to act as Informant for the purpose of the registration of the death. As to the person liable to act as Informant, see back.

DUTIES OF INFORMANT.

The Informant must deliver this Notice to the Registrar of Births and Deaths of the Sub-District in which the Death took place, bearing in mind that the Death cannot be registered until the medical certificate has reached the Registrar. Failure to deliver this Notice to the Registrar renders the Informant liable to prosecution.

The Informant must be prepared to state accurately to the Registrar the following particulars :—

(1) The Date and Place of Death, and the place of Deceased's usual residence (2) the full Names and Surname (3) the correct Age (4) the Occupation and (5) whether Deceased was in receipt of a naval or military pension, an old age pension, or other pension or allowance from public funds.

The Death Certificate

By KEITH SIMPSON, M.D.

YOU may think that in comparison with the attractions of murder and criminal abortion or some other diverting chapter in forensic medicine this subject could only be impossibly dull and unentertaining. But this is not so, for doctors in practice provide, both for themselves and for the police, a great deal of interest, no little perplexity and a liberal dash of humour in their manipulations of the death certificate. When the Editor suggested an article on a subject of general interest I had no hesitation in proposing this, for nothing is written of it and the average student and doctor in practice has a knowledge of it which does not stretch to any very obliging extent when it is tested. The examiner frequently tries it out on his victims and the medical practitioner even more frequently has the public try it out on him: both should be on familiar terms with the document.

For document it is, a proper legal document to which the doctor appends his signature quite voluntarily. There is no legal obligation: no one can force a doctor to sign the certificate whatever the circumstances, and the doctor has many natural as well as statutory reasons for refusing to do so. Even if he could state the precise cause of death and was qualified by his attendance to certify he could still refuse to do so. Occasionally, when a doctor wants to have an autopsy and the relatives refuse, the doctor achieves his end by refusing a certificate—on the grounds that until he has been satisfied by post-mortem he is not absolutely certain of the cause of death. The relatives have no recourse but the coroner, but if the coroner thinks fit, as he will when a doctor says he cannot state the cause of death, an autopsy will be ordered and the doctor's ends will be attained. This is making something of a convenience of the law and the coroner which would be improper except under some special circumstance, but it is a proceedure well within the law which illustrates the voluntary nature of the signature to the certificate.

No fee can be charged, and the doctor who slips in an odd 2*s*. 6*d*. on the account for it, as in a case I had early this year, commits an offence. The relatives in that case complained of the fee charged when they arrived at the registrar's office with it, and the registrar referred the case to the coroner. When I took the doctor aside and told him the reason for this dissatisfaction he flushed and said he thought his dispenser-accountant must have slipped the charge in in error; but I knew he made a habit of it, and I have no doubt he has now discontinued the practice. The sum was trivial, but the principle was an important one and such a practice might well result in his appearance before the G.M.C.

I have had somewhat similar cases where a doctor charged a fee for the post-mortem performance of a tracheotomy, appropriately enough over a butcher's shop, for what later proved to be bronchitis; and another, in which a doctor accepted a legacy for an obliging but unsuccessful search for the radial artery which it was desired should be cut to ensure death before burial. These are trivialities in comparison with what is a clear-cut offence—charging a fee for the death certificate. Such a practice, if allowed, would result in some less reputable doctors ignoring the proprieties of certification and acquiring a popularity with those who wished to avoid enquiry after death. Crime and insurance benefit would thrive on such a practice. It is manifestly undesirable—and in law it is wrong.

Now let us look at the certificate for a moment. There are three parts to it. The certificate of death itself lies in the middle and on its right side is attached the notice to the informant. The left-hand attachment is for the doctor who desires to keep a check on his issues. Let us detach the "Notice to Informant" first. This is a kind of counterfoil which the relatives or a housekeeper or some other person present at death or keeping the establishment where death occurred take to the registrar so that he may know to whom to give the order for burial—when he receives the death certificate. In a case where a taxi-driver obliged his "fare" by going up to her flat with her "for the change" and who died of heart failure during the proceedings the prostitute herself had to act as informant; and in another case where a woman, who was entertaining a man in the absence on night duty of her husband, was faced with the same predicament the coroner's officer kindly acted as informant—and also contrived to remove the body before 8 a.m., when the husband was due home. This part of the certificate need give no difficulty; even the doctor may act as his own informant, taking the certificate and this counterfoil to the registrar. The registrar will, on receipt of both, give the informant the order for burial.

The certificate proper is the doctor's chief responsibility. It says quite clearly at the top :—" For use only by a Registered Medical Practitioner who has been in attendance during the deceased's last illness . . . ." ; and again at the bottom, " I hereby certify that I was in medical attendance during the above-named deceased's last illness. . . ." Then follows signature and qualifications.

So no doctor not registered as a medical practitioner can sign such a certificate, nor can he do so unless he has been in attendance during the last illness. It is not enough for him to know the details of the case from his partner or the secretary or the locum tenens. It is even improper for him to have attended a man for hypertension and to issue a certificate for a cerebral hæmorrhage when he hears his patient has had that long-expected " stroke " ; only if he has again attended him for this last illness and recognises its nature can he fill in and sign the certificate. I am every day finding by post-mortem in such expected " strokes " varieties of death far removed from cerebral catastrophes—unsuspected pulmonary tuberculosis, ruptured aneurysm, coronary thrombosis, fractured skull and contused brain or broken neck from collapse and fall for example. As a means of ensuring that the doctor does not overlook this matter the certificate says, after the preamble of name and address of the patient, " last seen alive by me." If never seen alive—and that means seen professionally—the patient's death cannot be certified by any doctor, whatever he has heard about the subject. I recently examined a case where the relatives had successfully persuaded a doctor to sign a certificate for " arteriosclerosis and heart failure " on the grounds that he had, in attending the house to look after the children, often seen this old boy of seventy-eight tottering about, and had frequently had a word with him. That doctor issued a certificate without even going to the house to assure himself that the old man was dead. He was caught by that covering clause " Last seen alive by me " ; he could not fill in any date, so he left it open, and the registrar quite rightly refused to accept the certificate.

The law requires a doctor to have been in attendance in life, and in most districts the registrar refers certificates in cases where the doctor has not been in attendance for fourteen days or more. This is merely a safeguard against an abundance of complications including crime, poisoning, accidents and the like which might have intervened to hasten death. True these might all take place in as little as twenty-four hours before death ; no system is without its weaknesses, but it is felt that fourteen days is a fair period to set where some natural disease is in progress, that if some other circumstance were to intervene the doctor would, as it was so close to death, be told by the relatives or friends—or would see for himself when he saw the dead body. But here the law is remarkably lax—for it does not require the doctor to see the body after death. This is a serious defect ; such a visit ought to be enforced, and I have on many occasions seen illustrated the wisdom of the doctor in insisting upon such a visit.

In one case the doctor was told of a woman whom he had attended some four months previously for angina being found dead in bed. She had complained of agonising chest pains shooting into the left arm on the previous night. The doctor was not surprised to hear that she was dead, and issued a certificate for coronary thrombosis based on the description of the pain given to him by the relatives. He did not go to see the body. As he had not visited for four months the registrar stopped the certificate and, on receiving the information, the coroner ordered a post-mortem. I found corrosive burns on the lips and some seven ounces of concentrated spirits of salts (HCL) in the stomach. The old lady had committed suicide, unable to stand the pain of her coronary thrombosis which she undoubtedly had. The doctor should not have ventured a certificate four months after his last visit, and enquiry further showed the importance of seeing the body after death. In truth, how can a doctor know without a visit that there is a dead body at all.

Last year I had a case in which relatives asked the B.B.C. to broadcast the following gem : " Will Dr. R. L. W——, who attended Mrs. Mary Ann C——, of 102, Chaucer House, T—— Street, London, for bronchitis and heart disease please forward certificate of death to above address as soon as possible. Death occurred on September 18th, 1942. He last saw her for Dr. B—— on September 6th, 1942." Neither doctor could be found so the relatives tried the B.B.C.—who naturally refused. The coroner dealt with the case.

Well, there it is. Dangerous as it may seem—as it obviously is—the law does not insist on a visit after death. How easy it must be for violence to terminate a long illness which is holding up legacies from relatives itching to lay their hands on the money. I have had a number of cases where anonymous telephone callers have informed Scotland Yard or the local police that such an event is being hushed up by

the doctor and relatives as a natural death, but so far I have not had any safe grounds from autopsy to justify the police interrupting the ceremony by a criminal charge. There have, however, been several cases of this kind, but where money was not involved, in which enquiry has exposed crime.

A young mother called on the doctor who had been attending her only child for bronchitis as the infant had been found dead in its cot. Now that doctor had seen the child only two days before and it then had bronchitis. It might well have died from asphyxia from accumulation of secretions in its sleep. But he made a practice—a wise one, as it turned out—of seeing his patients after death, to make sure they were dead, and to satisfy himself, as he said, that they had not been strangled. It was prophetic. On his visit after death the mother said she had fed it at 9 a.m., but it had cried a lot and she had gone back at about 11 a.m. to settle it down. When she went next, at 12.30 p.m., it was dead in its cot. The doctor saw several little bruises on the face and the mother said it had been so restless perhaps it had " banged its little face against the cot." The doctor did not feel quite satisfied as to the precise cause of death and reported the case to the coroner. When I opened the chest and abdomen at autopsy fragments of liver and spleen floated out in a stream of blood. Seventeen ribs were fractured and chest and abdomen were heavily crushed. The marks the doctor had noticed on the cheeks were caused by fingers and opposing thumb marks were found in the nape of the neck ; the child had clearly been gripped by the head and swung hard against the bed or the door or the banisters or some such surface. When the C.I.D. questioned the mother she denied any knowledge of violence, but when told what the medical evidence would be, she confessed she had gone to it at 11 a.m., not to comfort it, but because she lost her temper with its crying, and had " picked it up and bashed it on the edge of the door." She was charged with murder and later convicted of infanticide, the Director of Public Prosecutions agreeing to this reduction in the charge.

In infants another question arises. Can the doctor tell whether a dead child, newly born, has had a separate existence or not. Of course he cannot, from external examination, say that it has ; he might be able to say, if it were macerated, that it could not possibly have had a separate existence—but never that it had. I remember a doctor who was sure about the question—though he could only say it was because the child was pink—being unable to say what the sex of the child was. It was sheer guesswork and did nothing but detract from his integrity as a doctor. The doctor does not benefit by making such guesses ; he only takes thereby a responsibility, and for no fee, which may result in discredit to him. He would have been wiser to say he did not know, and correct to say that no one could tell until a post-mortem examination was made.

So much for the question of seeing the subject. What of the precise description of the cause of death ? Now there are certain kinds of death which, for very obvious reasons, cannot be certified by a doctor. In a list which is circulated at Guy's to house officers these are set out under these headings :—

A. *Violent or Unnatural Deaths—*
   (*a*) Accident or injury, whether within a year and a day or not.†
   (*b*) Drugs or poisons, including alcohol. Food poisoning.
   (*c*) Industrial disease.
   (*d*) Want, exposure, neglect (including neglect by others).
   (*e*) All abortions and maternal deaths if in any way suspicious.

B. *Deaths, the Cause of which is Unknown—*
   (*a*) Cases brought in dead—seen only after death.
   (*b*) Where the cause of death is not properly known.

C. " *Anæsthetic* " *Deaths—*
   Not yet recovered from effects of anæsthetic (or within twenty-four hours of its administration).*

D. *Deaths of Persons who have Suffered from a Pensionable Disability—*
   From war or occupation.

† Only where a criminal charge is concerned is a time-limit set on the relation of injury to death.

* Variable instructions from different coroners' districts.

In such cases the doctor should not attempt to issue any kind of certificate. By informing the coroner the doctor transfers to him the responsibility of making out the document ; unless the doctor is asked to send a report or attend the coroner's court to

give evidence on the case he has no further duty to discharge. It is unfortunate that the reverse aspect of the death certificate bears a space marked, " I have reported this case to the Coroner," to be filled in if applicable, for if the doctor has reported the circumstances to the coroner he has no need to issue any kind of certificate : to do so is a redundancy. If the case has already been reported to the coroner it is only confusing to repeat the information *via* the registrar and after postal or other delay. In practice the doctor telephones the coroner's officer or the local police who transfer the message. No delay then ensues.

In cases where the conditions set out above do not apply a certificate may be issued. The vast majority of deaths fall into such a category. The medical practitioner, duly registered, has been in attendance during the last illness, knows the cause of death and has no cause to suspect that any of the conditions set out above have had a part to play in the causation of death. All that remains is for us to discuss the precise wording of the entries made in the space allotted for " Cause of Death."

It is set out in two sections. The first, headed I, asks for—(*a*) the " Immediate cause " and (*b*) " morbid conditions, if any, giving rise to the immediate cause." It would be sufficient to write, for instance, " Acute general peritonitis " under (*a*) and " Perforated gastric ulcer " under (*b*). Then follows a second section, headed II, asking for " other morbid conditions (if important) contributing to death but not related to immediate cause." There would be none in the example given, but if we were to have written " Uræmia " due to " Suppurative pyelonephritis " we might properly place in this II section " Carcinoma of the prostate," or whatever it was. We might, under other circumstances, write " Diabetes mellitus " if such a disease had contributed to the development of an infection of this kind.

You may think that this question of filling in the details of the cause of death is quite simple. All that is asked is that a precise cause of death should be set out, starting from the immediate cause and working back to the underlying disease responsible. The certificate has a footnote asking you to avoid the use of terms merely describing the mode of dying such as heart failure, coma, asthenia, etc., under the " immediate cause." If you do not know the precise cause of death then you should not attempt to fill in anything. It is your duty to report such a case to the coroner.

The woman doctor who wrote " Morbus cordis " as the sole entry in a case I had recently was indulging in a stupid and meaningless brevity of expression and the " Nathan B——, M.D.", who wrote :—

> " Heart failure.
> Arteriosclerosis.
> Senile arterial degeneration over a long time.
> Dec., 1936.—Hemiplegia and aphasia.
> Sept., 1937.—Another cerebral hæmorrhage.
> July, 1938.—Another cerebral hæmorrhage.
> Aug., 1938.—Heart attack . . . .

went to the other extreme, being informative to an absurd degree.

It is wise to avoid ambiguities like " Birth injuries " and " Termination of pregnancy," qualification of which must be given to make it clear that they were natural and not accidental or criminal. " Fibrosis of the lung," without qualifying its nature, often gives rise to trouble, the registrar stopping the certificate for enquiry about the possibility of an industrial origin. Vagueness of any kind is certain to result in the certificate being referred by the registrar to the coroner for further enquiry.

It is hardly necessary to add that deliberately overlooking a circumstance which may (not necessarily must) have had a bearing on death is an offence. It matters not that the relatives have no desire to have the matter enquired into or do not seek to benefit from it. The pompous practitioner who said, in a case of this sort which I had : " Leave this to me ; you'll hear nothing more of this " was exposed by the undertaker, who observed heavy bruising of the hip and shortening with eversion of the leg and who suspected a recent fracture of the femur which he knew from experience with the coroners' courts commonly accelerated death. He was right and, far from hearing nothing more of it, an unusually spirited enquiry preceded burial.

If you are familiar with the limits of your power to issue a certificate, clear in your mind as to the natural cause for death, and able to put it down in writing, you will never have the indignity of having a certificate refused. Give it the attentions you would give to any other legal document affecting your interests and you will have no cause to regret your signature.

"Jacobsoniana"

Pom had many of the qualities which have made Don Quixote beloved by millions, so many hundreds of students loved him deeply. He believed it to be his duty to help the students; they all felt this and that his rudeness was meant as a goad to make them work. At Out-patients' one of them received this rebuke without resentment: "Only a week ago I told you how to recognise a hydrocele, and now you know nothing about it, you ignorant young idler! I shall write to your father this evening asking him to remove you from the profession."

The immense trouble he took in teaching was rewarded by crowds at Out-patients' and in the lecture theatre. Often a synopsis of the clinical lecture was printed on slips which were given to the audience. Once a student who failed to get one, asked for it after the lecture. Pom picked up one, saying: "Take it; I had meant to keep it for myself." The Student: "Then, sir, I could not think of taking it." Pom: "You don't want it and only asked for it to flatter me." Student: "I am sorry if you think that; I will take it." Pom: "Take it and go, selfish pig."

An old dresser called at Jacobson's house to make an appointment to bring a patient. "Gratuitous, I suppose?" said Pom. These rudenesses did not arouse resentment, only amusement; they were regarded as merely "Pretty Fanny's way." As I worked under him for many months I had at times to call at his house in Finsbury Square. I was going to sit on a chair. He cried: "No, not on that; it was my father's, the Lord Bishop of Chester's chair. On second thoughts, I have known you so long that you may sit on it." He asked me to take a message to Howse, his corresponding surgeon, and gave me some cigars for Howse's man-servant. I heard someone running after me in the dark. Jacobson panted up, saying: "Give me those cigars. Mr. Howse does not smoke and I must not pollute his house."

Letters to My Nephew

By "UNCLE HARRY."

MY DEAR GUY,—I am glad to hear that you've got over your attack of dysentery. Rotten thing while it lasts, isn't it? I've had it seven times and am beginning to think I know something about it. And, speaking of dysentery, I wonder whether you read a recent article on the treatment of dysentery at sea? If not, you should, because it gives a perfect picture of the doubt which assails men who are evidently confronted by a disease with which they are not very familiar.

The patient was said to have "frequent stools" and, in the absence of sodium sulphate, they gave him magnesium sulphate, which was quite correct. I remember over thirty years ago when magnesium sulphate was regarded as *the* treatment. But in those days one never heard much about *bacillary* or *amœbic* dysentery. Dysentery was looked upon as a disease with a separate entity and not a mere syndrome indicating ulceration of the colon.

Because of the very different treatment of the two varieties it is of the greatest importance to distinguish one from the other. It is always satisfactory to have one's diagnosis confirmed by the lab., but, for the love of Mike, never wait for your diagnosis until the lab. makes it for you. Sooner or later you may have to cope with an outbreak where there is no lab., as happened in the case quoted, which occurred at sea; and your diagnosis and subsequent treatment will depend entirely on your own clinical knowledge and experience. Your own personal experience of bacillary dysentery will give you valuable knowledge of the disease which will stand you in good stead in the future. The two diseases which every Service medical officer should know inside out are dysentery and malaria. Now let me quote from the report of the case.

Writing on what was apparently the third day, the authors say:—"The bowels continued to act frequently, blood and mucus being passed. This continued for the next twenty-four hours, when the evening temperature was 102 deg. *The possibility of amœbic infection was considered and it was decided to try an injection of emetine hydrochloride* 0.03 *g.*"

The *italics* are mine, and they plainly show doubt and inexperience. Why? Well, consider the differential diagnosis of the two varieties (coupled with your own personal experience). How can they be distinguished clinically?

Firstly, temperature. Acute B.D. is a febrile condition in which the temperature may range from 100 deg. in slight and mild cases to 104 deg. in severe. *Uncomplicated amœbic dysentery is apyrexial.*

Secondly, stools. Mild attacks of acute B.D. may result in nothing more than slight abdominal discomfort and one or two loose stools. In more severe cases the stools may be literally uncountable, hence the poetic description of the patient being "glued to the commode." At first they are fæculent in appearance, then they become liquid and, as their frequency increases, smaller and smaller, losing their fæculent colour until they may be no more than a couple of teaspoonfuls of blood-stained mucus, the passage of which is accompanied by undiminished colic and tenesmus. In amœbic dysentery the stools have been described—with that *penchant* for likening pathological products to *delicatessen* or other articles of food which seems to be distinctive of our profession—as resembling anchovy sauce, which they certainly do. But not in odour. Whereas the small mucoid and almost colourless stools of acute B.D. have practically no smell, or very little, those of amœbic dysentery are extremely foul.

Thirdly, toxæmia. In acute B.D. the onset of toxæmia may be rapid and deep, so that it is possible for a patient to be killed by it before he has had a single dysenteric stool. Its severity depends to some extent on the identity of the causative organism, *B. shigæ* having by far the worst reputation. In amœbic dysentery the toxæmia is absent or not noticeable.

By the way, when your cousin Guy got his first attack in Egypt I noticed that he was stretched out on a chair on the verandah, when I arrived home from H.Q. He got to his feet very unsteadily and said: "I think I'll go to bed." He was so tottery that I helped him into the bedroom, undressed him, got him into bed and took his temperature, which was 104 deg. I went out to wash the thermometer and, when I came back to examine him, he was comatose. I turned down the bedclothes and found he had passed a considerable amount of blood involuntarily, so I covered him up and rang up for an ambulance. Then I rang up the officers' hospital and said to the matron

who answered it: "I'm bringing my boy in at once with acute bacillary dysentery. Will you have a bed ready for him, matron?" As you know, Guy is six feet two inches and has four R.A.F. Rugger caps. You will see the joke when I tell you that on arrival at the hospital the matron, who did not know Guy, had a beautiful little cot all waiting for my "boy"—bless his little heart!

Old Peter, whose wife was one of the wives who died from acute B.D. in that awful hotel which I described in a previous letter, had to treat her himself. He had exactly the same doubts as those which assailed the authors of the report. First he thought she had acute B.D. and gave her sodium sulphate. Then, when she didn't respond *immediately*, he thought it must be amœbic and pumped in emetine. To this day I wonder whether it was the emetine or the bacillary dysentery which killed her.

In my own last three attacks of acute B.D. I had to treat myself, with the assistance of your aunt. I took two drams of sodium sulphate every four hours for the first three days, then every six hours. I got some colloidal kaolin specially flown out to me from Cairo and took a heaped dessertspoonful every four hours, and that was all I could get. My diet was veal tea every two hours with an occasional cup of water arrowroot. In four days the stools began to recover their normal fæculent colour, but were blood-stained for a further week. My temperature ranged from 100 to 102 deg., and I drank lashings of barley water with lemon. Yet with this simple treatment I was out of bed in under a fortnight.

The authors of the report appear to have found salvation at last in sulphapyridine, which is effective though unpleasant to the patient. Nowadays the remedy of choice is sulphaguanidine, its first cousin, which, I expect, you are now familiar with. I have used it for three years, before it actually was on the market, thanks to the courtesy of the makers.

Well, what is the moral of this letter? Do you remember the man who received a telegram, "Mother-in-law dead. Shall we embalm and bury or cremate?" He replied, "Do all three. Leave nothing to chance." If he could have been convinced that she was really dead, think of the money he would have saved!

There are some conditions one meets with in practice in which it is legitimate and even wise to have a "bob on each way"; but dysentery is not one of them. Clinical differentiation between its two main varieties can be made with a high degree of accuracy, but for the love of Mike don't pump in emetine while you are filling 'em up with sulphaguanidine. If there is a lab., use it.

Your cousin Guy is in hospital recovering from pneumonia. Dorothy is still in Washington with the W.A.A.F.s, where she has now been for over two years, with little chance of posting to a Home Command because, apparently, there is nobody who can do her specialised job. Your aunt joins me in best love.

Your affectionate,
UNCLE HARRY.

Sector News

Guy's Letter

AS at a similar period last year the staphylococcus has made its appearance in Victoria Ward and necessitated the opening of the upper regions of Nuffield House to obstetric cases. The Eye Ward has done its bit by accommodating the toxæmias in addition to its already varied population.

The trench shelter in the Park has, after a long period of disuse, had its entrances sealed. It has also lost one "limb." Many will remember the energetic days they spent with pick and shovel shortly before the outbreak of war on the construction of this hospital W-plan and the bones of plague victims and oyster-shells which came to light in the process. Then there were the half-segments of the old iron laundry chimney which were transported from behind the New Pathology Block, out into Borough High Street and back into the hospital again by the works department entrance, to form the roof of the shelter. These will be valuable as scrap-iron.

The Residents have been joined by Strathie and Gardner, and, more recently, Coupland, Trethowan and McCallum. Geoff. Dhenin has gone into the R.A.F., while a familiar figure, sometime author of this letter (I mean Ripman, of course) has lately been visiting us attired in khaki.

Social activity has been somewhat eclipsed by the M.B. exam., but there has been a dance in the Nurses' Home, as usual a successful and enjoyable function, while there continues to be regular gramophone recitals every Wednesday evening, also in the Nurses' Home.

The strange noises which emanate of an evening from the interior of the Female Annexe are, it is understood, connected with Bill Trethowan and the piano and have nothing whatever to do with the Ministry of Health's campaign. There seems to be prospects of a Resident's play in the near future. Tom Hills will, of course, be producing it and the usual standard of excellence may be assured. For those who have no knowledge of the histrionic abilities of a Guy's man in the annual play, the past numbers of the *Gazette* may be consulted and the spirit of pre-war Guy's can be gauged therefrom.

R. L. M.

Correspondence

INCREASE OF SALARIES FOR NURSES.

To the Editor of the GAZETTE.

SIR,—It is with regret that we read of the proposed permanent increase in the salaries of nurses in training.

Before the publication of the Rushcliffe Report we were hoping that after the War the block system would come into operation, and that we should be treated rather as nursing students than as probationers. If this were the case we should neither expect nor desire any increase in salary, but even a decrease, while we should hope that it would be easily possible for any girl of suitable ability and inclination to enter the profession by means of scholarship or bursary.

Although we appreciate the urgency of encouraging recruits to nursing, we note with regret that this is to be attempted by presenting it as a profitable job for girls of eighteen, rather than as a profession for which a professional training is at once essential and easily obtainable.

We cannot express too strongly our anxiety that, while every reasonable endeavour must be made at the present time to attract student nurses, this will not be done at the expense of imperilling the standard of the S.R.N., and that if the recommendations of the Rushcliffe Report be adopted some effective guarantee will be given that the present status of the Final State Examination will not suffer.

Yours, etc.,

Nurses' Home, Guy's Hospital. J. ROBIN TANNER.

PICTURES OF DISEASE.

To the Editor of the GAZETTE.

SIR,—I, and many others, have noticed the difficulty in getting a complete picture of disease without a terrible waste of time; also that the interrelationship of anatomy, physiology and pathology with resultant clinical picture is sketchy. I have a scheme which will, I hope, overcome these difficulties.

It is that a survey of disease in the form of an exhibition of self-explanatory type should be produced by combined effort. For example, carcinoma ventriculi; the essential anatomy for understanding function and surgery and a summary of gastric function would be displayed in pictures and text. This would lead on to the sections in which the various types of growth, their pathology, signs, symptoms, X-ray test meal and gastroscopic findings would be set forth. The essentials of surgical and medical treatment would complete the picture. References to the literature would be given. The advantages of seeing actual X-ray test meal, etc., findings from actual cases would alone be of great value. Low power drawings and microphotographic of the high power histological appearances would be another feature. I cannot go into detail, but you can, perhaps, visualise the advantages—especially to those who actually produce the goods.

Those who can draw and paint are especially asked to think over this as the success of the scheme would largely depend on the quality of the illustrations which are to be one of the main features.

Yours, etc.,

Pembury Hospital, Tunbridge Wells. CLIVE L. SHARP.

Sport

Rugby

GUY'S *v.* AN EASTERN COMMAND XV.

(*Played at Honor Oak Park on February 6th.*)

Guy's continued their smashing form by defeating an Eastern Command XV. Fore and aft Guy's were superior in every phase of the game, and their team work was so highly developed that the game of Rugby football was made to look simple. Once again the three-quarters passed with clockwork precision, with the full back joining in the attack.

The Command were the first to score through Milman, who crossed from a forward rush and Troughton converted. Brangwin replied for Guy's immediately for Lewis to convert and, following some nice three-quarter movements, N. K. Macrae-Gibson scored.

Candler failed to convert a try which he made for Miles, and with the score level, Guy's settled down to give a polished display. A. C. Macrae-Gibson crossed in the corner; Lee, with a determined effort, scored under the posts and, following a nice bout of passing, Strathie's opening led to Brangwin crossing again. Lewis converted the last two tries.

Result: Guy's, 3 goals, 2 tries (21 points); An Eastern Command XV, 1 goal and a try (8 points).

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, P. L. Brangwin, D. M. Strathie (captain), N. K. Macrae-Gibson; W. H. Lillywhite, R. N. H. Vann; B. H. Wilshere, A. B. Lee, A. Batty-Shaw, A. G. Albers, D. L. Gullick, S. M. Hilton, C. Vidot, P. D. Harvey.

GUY'S *v.* H.M.S. "DÆDALUS."

(*Played on at Honor Oak Park February 13th.*)

H.M.S. Dædalus, a Fleet Air Arm Station, were the third naval side to suffer defeat on the home ground this season.

For the whole of the first half both sides were guilty of much faulty passing, and with defence supreme over attack the score was kept down to a penalty goal kicked by Lieut. Campion for "Dædalus."

The Navy were unfortunate to lose a man in the second half, but this should not have accounted for such a collapse, when Strathie, Lillywhite, Willcock, Lee and Wilshere literally made rings round the opposition. A rapid succession of tries, as a result of accurate passing and fast running, came from A. C. Macrae-Gibson (2), N. K. Macrae-Gibson (2), Harvey, Lee and Lillywhite, one of which Gullick converted.

There was nothing more delightful than the elusiveness of Strathie, and the excellent play of the forwards in the loose.

Result: Guy's, 1 goal, 6 tries (23 points); H.M.S. Dædalus, 1 penalty goal (3 points).

Team.—E. K. Harris; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie (captain), T. P. Dalton; W. H. Lillywhite, R. N. H. Vann; I. H. Hilliam, A. B. Lee, R. G. L. Brittain, A. G. Albers, D. L. Gullick, B. H. Wilshere, C. Vidot, P. D. Harvey.

GUY'S *v.* METROPOLITAN POLICE.

(*Played at Honor Oak Park on February 20th.*)

This game was mainly a forward battle, and although the Police, through the excellent hooking of Dai John, had more of the ball in the back division, they made poor use of it against Guy's sterling defence. The only score of the match came in the first half from a run and punt ahead by Masters, which Webber followed up and touched down for Pridmore to convert.

Guy's had a fair share of the game, especially in the loose, and several times raised hopes of a score, but the Police always managed to clear their lines by sound defensive play.

Score: Guy's, nil; Metropolitan Police, 1 goal (5 points).

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, P. L. Brangwin, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. N. H. Vann; I. H. Hilliam, A. B. Lee, R. G. L. Brittain, A. G. Albers, D. Gullick, B. H. Wilshere, C. Vidot, P. D. Harvey.

Hockey

GUY'S 1ST XI *v.* ST. MARY'S HOSPITAL.

(*At Honor Oak Park on Saturday, January 30th.*)

Won 2–0.

We completed the double over St. Mary's Hospital with a well-deserved 2–0 win at H.O.P. Guy's did the majority of the attacking in the first half, which produced some very fast and open hockey. Burt scored about half-way through.

The hockey was not so good in the second half, both teams keeping the ball too close. Thompson was an exception and sent in many excellent centres from the right wing. Our forwards looked more dangerous all the way through the game, but often failed to finish when near the circle. Burt scored our second goal shortly before the end of the game. Richards and Parr were both in their best form in the half-line.

Team.—R. S. Smith; B. H. Prideaux, E. A. Glover; J. R. Dimock (captain), J. G. Richards, P. T. Parr; G. Thompson, T. C. L. Parry, J. R. Burt, D. R. S. Saunders, J. D. Trethowan.

GUY'S *v.* UNIVERSITY COLLEGE HOSPITAL.

(*At Honor Oak Park on Saturday, February 6th.*)

Won 6–0.

Our opponents were not up to the standard of some of the other hospitals and allowed us to win easily.

Thompson (2) and Glover (short corner) gave us a 3–0 lead at half-time. Thompson, Saunders and Wotton scored our three second half goals. Once again it was our defence which took control of the game and kept the ball almost entirely out of our own half of the field. The few rushes our opponents did make were usually broken up short of our circle. Glover and Prideaux at back were never beaten and Smith had nothing to do in goal. Richards fed the forwards well with through passes and had the forwards been in their best form there might have been several more goals.

Team.—R. S. Smith; B. H. Prideaux, E. A. Glover; J. R. Dimock (captain), J. G. Richards, D. C. Dawson; C. M. M. Jenkins, G. Thompson, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

February, 1943.

Pass.

P. L. Masters
R. T. Parkin
T. L. Reeves
G. R. McK. Sichel
M. N. Teubes
D. J. Tibbs

Supplementary Pass List.

PART I.

T. M. Ball
R. A. Bush
R. N. M. Eminson
R. I. McCallum
T. Koonvisal
P. E. Mars
S. A. Marsh
L. G. C. Martin
W. A. Porter
E. A. Williams
O. H. E. Williams
E. G. Wright
C. J. Zerny

PART II.

S. H. Bockner
J. T. Doyle
R. I. McCallum
L. G. C. Martin
J. D. Paulett

PART III.

F. G. B. Dodd
G. M. Evans
M. F. Hart
J. F. Horley
A. C. Macrae-Gibson
C. J. Zerny

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

February, 1943.

Surgery.—*E. A. Williams.

Medicine, Pathology and Forensic Medicine.—J. S. Pegum.

* Has completed the examination.

Change of Address

W. Mark Brown, Major, N.Z.M.C. (19292), Middle East Forces.

W. Holmden, Ft.-Lt. (D.) R.A.F., H.Q. 297 R.A.F., West African Forces.

V. H. Martindale, Surg.-Lt., R.N.V.R., H.M.S. "Jed," c/o G.P.O., London.

A. E. Ram, Capt., I.M.S., c/o Grindlay & Co., Bombay.

Papers by Guy's Men

Neustatter, W. Lindesay. Hysterical Amnesia in Soldiers, and some Medico-Legal Implications. *Practitioner*, 1943, **150**, 35.

Pilbeam, P. F. Senior Dental Officer and the Future of Public Dental Service. *Public Health*, 1943, **56**, 58.

Marshall, Geoffrey, and Another. Massive Collapse of the Lung. *Practitioner*, 1943, **150**, 71

Layton, T. B. The Beveridge Report and the Medical Profession. *Lancet*, 1943, i, 56.

Symonds, C. P., and Another. Accidental Head Injuries. Prognosis in Service Patients. *Lancet*, 1943, i, 7

Clarke, D. Stafford. Aspects of War Medicine in the R.A.F. *Brit. Med. J.*, 1943, i, 139.

Traill, R. R. Pleurisy and Pleural Effusion in Differential Diagnosis. *Brit. Med. J.*, 1943, i, 98.

Barber, H. W. Two Cases of Generalised Vaccinia (Vacciniola). *Proc. Roy. Soc. Med.*, 1942, **36**, 43.

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Cautley, R. L. Vincent's Infection. *Brit. Dent. J.*, 1943, **74**, 34.

Cameron, H. C. The Common Cold. *Clin. J.*, 1943, **72**, 1.

McEvedy, Peter G. Ulcerative Colitis. *Clin. J.*, 1943, **72**, 4.

Ryle, John A. The Analysis of Pain. *Clin. J.* 1943, **72**, 7.

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Rix, E. Ernest. A Dental Characteristic of the Jews, *Dental Record*, 1943, **63**, 39,

Broster, L. R. Crush or Compression Injuries. *Medical Pr.*, 1943, **209**, 78.

Gill, W, G, Gynæcomastia or Male Mammary Hypertrophy. *J. Roy. Naval Med. Service*, 1942, **28**, 333.

Beach, W. V. Giant-Cell Tumour. *J. Roy. Naval Med. Service*, 1942, **28**, 339.

Braithwaite, J. Vernon. Common causes of Stridor in Infancy, and their Treatment. *Practitioner*, 1943, **150**, 31.

Mentioned in Dispatches

Flight-Lieut. P. M. Davies, R.A.F.V.R.

Prisoners of War

Malaya : Captain E. D. H. Williams, R.A.M.C., Major W. H. Dowell, R.A.M.C., Captain J. A. Glover, R.A.M.C., Captain M. T. O'Sullivan, R.A.M.C., Captain C. S. Pitt, Captain T. S. Protheroe, R.A.M.C.

Births

CHRISTIAN.—On February 20th, 1943, at the Middlesex Hospital, to Nancy, wife of Harold Christian—a daughter (Anna Susan).

KARK.—On February 25th, 1943, at Bicester, Oxon, to Lorna, wife of Ft.-Lt. C. V. Kark, R.A.F.V.R.—a daughter (Janeen Wendy).

LOCKWOOD.—On February 22nd, 1943, at the Cottage Hospital, Builth Wells, to Pat, (née Mathias), wife of Major J. F. Lockwood, A.D. Corps—a son.

Deaths

DODD.—On February 23rd, 1943, Lieut. Edward Frank Samuel Dodd, L.D.S., R.C.S. (Eng.), of 47, Beauval Road, Dulwich and 71, Peckham Road, S.E., aged forty-three years.

EDS. { P.F.E.B. J.O.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

A LETTER appeared in the last issue of the *Gazette* under the title "Pictures of Diseases," which might well have been labled the "Subject of Teaching." It proposed the inauguration of an exhibition, a symposium on one disease, in which would be gathered together all the present knowledge of that disease. An example, carcinoma ventriculi, was given. The exhibits would show, not only pathological and clinical studies of the morbid, but anatomical and physiological studies of the normal. Detailed drawings would be there, annotating the microscopical exhibits and X-rays, together with text-books and the available literature on the subject. Expositions of the treatment, medical and surgical, with the prognosis would complete the whole picture of the disease.

This proposal is very much like that already carried out in the Wellcome Museum, as a letter later on in these pages points out, and a very good idea it is, too—in its place. But is Guy's the place for such an exhibition ?

There are many reasons why such an exhibition would be impossible to contemplate in these days, the outstanding one being that of housing. Would the exhibition be at Guy's or in the Sector ? If it were to be permanent it would best be situated at Guy's, but at the present time it would be more useful if organised in one of the Sector hospitals. Another hinderance is the availability of material. When in the Sector, the students may have opportunity and time to carry out the proposal by their own efforts. But is such an exhibition necessary for our study of different diseases ? Does it not come under the title of a "luxury" nowadays ? It very nearly comes under the heading of "spoon-feeding." Not that the gathering together of all such material is a bad thing, but the exposition of that material should be such that the mind of the student should be stirred to think. Even in the Gordon Museum now no highly detailed reports are attached to the specimens, but just enough information for us to work out the details for ourselves. Material should be available, perhaps not so easily accessible now in war-time, but enough for anyone to study.

But once again may we say that the idea in itself is a good one, and, perhaps, in better times, in the new Guy's that will be built, some space will be found, if necessary, to provide a home for such an exhibition. In the meantime, to our minds there is a partial answer to the letter's demand—that is, the Physical Society. In former days the Society, the oldest of its kind in London, used to hold very successful meetings with just that object in view—namely, the correlation of all data, clinical, pathological, histological, etc., to elucidate a case. Combined meetings with St. Thomas's, as with the other societies in our own Hospital, were often held. An exhibition on a small scale might well develop from a successful meeting of the Physical Society.

IN most cases the filling in of official forms is a most dreary task, but the person who reads them later may sometimes catch a gust of unexpected humour. In the form to be filled in for Service casualties there appears two questions to be answered by the examiner :—(1) Has the disability, in your opinion, resulted from enemy action, air-raid or other warlike operation ; (2) was the injury sustained on duty. Both these questions have to be answered, under the diagnosis made of the case. We have seen two or three diagnoses of pregnancy.

WE are starting something new in this issue of the *Gazette*, a new form to the Rugger reports. Previously the write-ups of the games have been in the same form as that appearing in the daily Press, and several criticisms were made against them. They were very short ; they were in minute print ; and they always were very late in appearing. For the end of this season we hope that the write-ups will be in legible print, of a readable nature, and up to date with each issue of the *Gazette*.

Guy's in the "Blitz"

By P. M. F. BISHOP, B.M., B.Ch.,
Medical Officer-in-Charge, E.M.S., and Deputy Superintendent, Guy's Hospital, London

I.

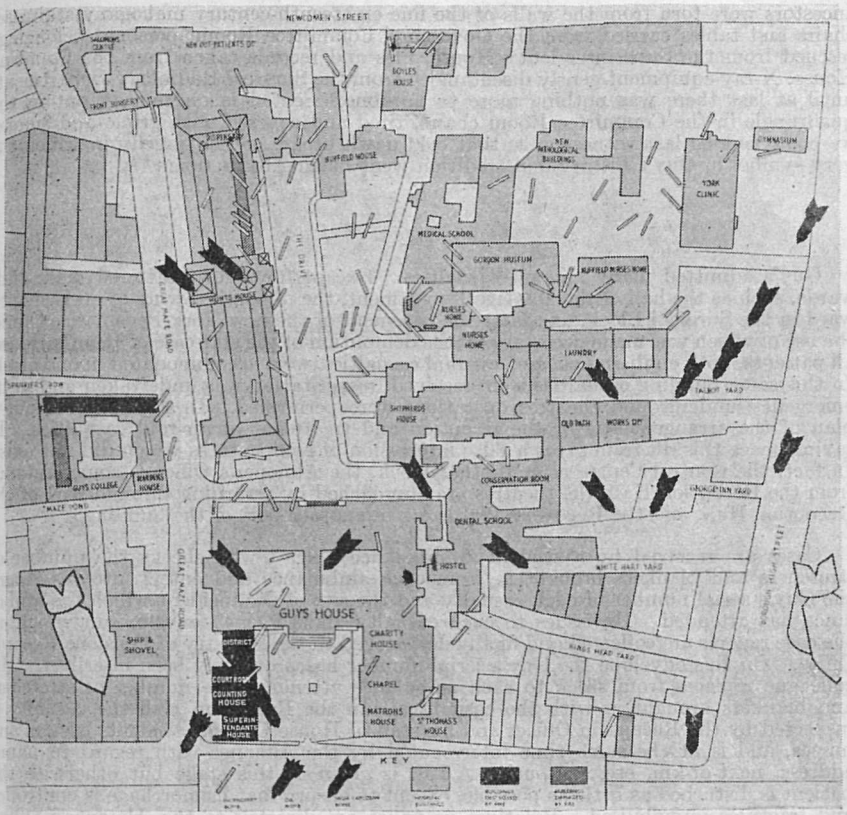
IT had been anticipated that Guy's would see action when the German bombers came to London. Lying back a little from the south bank of the river between Tower Bridge and London Bridge, the first two bridges to be encountered as the plane flies up the Thames estuary, it is but a stone's throw from London Bridge station. The warehouses, factories and markets of Bermondsey and Southwark, on the boundary line of which the hospital stands, are its close neighbours. These two of the most bombed boroughs in the British Isles were crowded with the rickety houses and tenement dwellings of those good London citizens, the dauntless people of the Borough. What better military objectives could be desired? And so the "blitz" came to Guy's. By the time the last bomber droned away in the early dawn of May 11th, 1941, Guy's had been hit by several high-explosive bombs, and showered with many incendiaries, besides being shaken to its foundations by many a near miss, and scorched with the flames of nearby blazing warehouses licking hungrily at its gates. Anxiety, relief, excitement, exhaustion, pity, anger, admiration—all these emotions had chased each other rapidly through the kaleidoscope of our minds.

II.

Many memories stand out vividly against the confusion of flames, smoke, dust, bricks and water which forms the background of recollection of these nine months. Those of us working at Guy's will remember the attack on the docks which opened the enemy assault on London; how during that night some of our patients had to be evacuated by Green Line ambulance to the country to make way for the casualties; the daylight raid in which nearby bombs brought casualties streaming into the hospital at the time when the morning's out-patients were beginning to arrive; the unexploded bomb which led to the evacuation of the Superintendent's Office and Stores and the Matron's Office for a time; the occasions on which more than a hundred casualties were admitted; the days without gas and drinking-water; the night when a big shelter close to the hospital was hit and many people killed and drowned, and how, with the road blocked to ambulances, students helping with the rescue work carried the patients back to the hospital on stretchers; the terrors of nights like May 10th. These are things that many of us will never forget, but three nights will be recorded in the history of Guy's.

The first was September 15th, 1940, quite early in the Battle of London, when a bomb crashed through the dome of Hunt's House. The great staircase beneath was demolished. More than two hundred souls in the building escaped death. The only casualty was a medical officer who, concussed and bleeding from a badly lacerated scalp, had to be lowered from a fourth floor window down a fireman's ladder. Sixty patients were rescued from first and second floor wards by fire-escape and bedded down in the long out-patient hall in twenty-three minutes, and swarms of men and women of the Borough, forsaking their shelters, helped to do it. A fire broke out on the top floor and was soon under control, dowsed with water from buckets and even students' steel helmets. From that day on for many months access to about two hundred and fifty beds was denied us and for more than a year after the staircase had been partially restored every patient and all the paraphernalia of the wards had to be carried up and down it until one of the lifts could be repaired.

Guy's passed through the night of the Great Fire not wholly unscathed. Though it was left standing, an oasis in a desert of desolation, as the result of the events of that night, the flames from the locked and unwatched warehouses around, blown by the strong wind, could not be prevented from setting light to the residential College and to the Deep X-ray Department at the top of the already bomb-shattered Hunt's House. Moreover, of three of the few high-explosives that fell in London that night, one did irreparable damage to the Surgical Block; another, by bursting in a subway, reproduced many of the curious phenomena resulting from blast in a confined space; and the third smashed scores of windows in that glasshouse, the Dental Department. Fortunately, once again there were only minor casualties, and above the roar and



Drawn by Nelson Burgess

FIG. 1.—Guy's Hospital Incident Chart showing some of the various types of bomb that have fallen on the Hospital Buildings during the German air raids on London.

excitement of the battle of flames which was reaching a crescendo the sounds of these high explosives could hardly be heard and their effects were given only perfunctory attention at the time. The fires were consolidating their grip on three sides of the hospital. All the patients had to be evacuated by ambulance to the country; and, finally, all of the staff but twenty and some of the more valuable and portable equipment were removed to places of comparative safety. Thus for the first time in its history Guy's closed its gates to the sick for a few brief hours. Next morning, however, the dauntless out-patient could be seen picking his way among the debris to consult his doctor. The night had brought excitement, danger, damage, but also miraculous escape, and in the aftermath came an expression of friendship in need, for the deep X-ray plant was replaced from across the Atlantic and installed in the Guy's U.S.A. hospital at Seal. Even the College, proudly distinguished fifty years ago as the first residential establishment attached to a London teaching hospital, was now shabby and out of date and can be mourned only for sentimental reasons.

On the third historic night of April 16th fire again was our foe. Late in an adventurous night a canister of incendiaries emptied its bombs over the hospital. A fire in the roof of the Nurses' Home was proving anxious work when smoke was reported rising from behind the gable above the Governors' Court Room. An incendiary lodging here had escaped notice. The whole of the upper part of the building was full of smoke. Extinguishers and buckets were of no avail. A recently acquired trailer pump jammed and failed to carry water from the swimming-bath. The hydrants were empty. The Fire Service, alas, was only too busily occupied elsewhere until it was too late! Everything that could be moved was taken out of the burning building. Portraits of eminent

ancestors were torn from the walls of the fine eighteenth-century mahogany staircase, chairs and tables carried from the Governors' Committee Room, personal belongings rescued from the Superintendent's House, files and records taken from the Counting House, X-ray equipment gently disentangled from the Surgical Radiology Department, until at last there was nothing more to be done. Seated incongruously out in the quadrangle in the Committee Room chairs, tired and covered with grime and smoke, we could but be last witnesses, as that cold dawn broke, of the tragedy in which the very symbol of Guy's history and tradition went blazing to its doom.

III.

Guy's admitted many air-raid casualties. Except for a few scattered make-shift wards, such as the hall of the Massage Department, the unbombed wing of an L-shaped ward in the Surgical Block, and later the basement of the new York Psychiatric Clinic, the use of which was made necessary by the demolition of the staircase of Hunt's House, all patients, both civilian sick and air-raid casualties, were accommodated in one block. In this same building casualties were received, resuscitation was undertaken and in its emergency underground theatres operations were performed. In Fig. 2 is set out a plan of the arrangements for the reception and treatment of air-raid casualties. In saving space this diagram gives a false impression of compactness which did not exist. In fact, the Control Centre is in another block, the Almoner's Office is some distance from the Reception Hall, the theatres are approached by returning through part of the Reception Hall, and the Recovery Wards are in another part of the building.

Cases are received by a student " ambulance teller " who checks the number of stretchers and blankets brought in from each ambulance and enters into his record the Guy's serial number of each casualty and the site of the incident which the ambulance has attended. He issues to each casualty an M.P.C. 47 envelope in which all the case reports are collected and finally despatched to the Ministry of Pensions Records Office. On this envelope the Guy's serial number has previously been inscribed. His colleague replaces from stock to each ambulance attendant the number of stretchers and blankets brought in with the casualties. In the Reception Hall the casualty is inspected by the Reception Officer and his staff of House Officers, students, sisters and nurses, and is at the same time interrogated by the Almoner with regard to name, address, next-of-kin, etc. Routine A.T.S. is given at this stage but otherwise the patient is disturbed as little as possible, except to ensure that hæmorrhage is controlled and fractures immobilised. Relatives or police are directed to the Almoner's Office. Relatives and friends are offered a " shake-down " for the night until the " All Clear " sounds.

The casualty passes quickly to the Resuscitation Ward, where he is given reassurance, warmth, morphia if necessary, and a cup of tea and a cigarette, unless an abdominal injury is suspected. At regular intervals pulse rate and blood pressure are recorded. In more serious cases, unless these become steady and the colour improves in about half-an-hour, a transfusion is given—of blood if the loss of it is evident or surmised, otherwise of plasma. In the early days too many patients were transfused and too much blood was given. More than two pints seldom diminishes the operative risks further. Within half-an-hour or so of the admission of a batch of casualties the Surgical O.C., with one or two ward clerks to take notes, proceeds quietly on a round of assessment. Patients are disturbed as little and as infrequently as possible and an atmosphere of bustle is discouraged. Clothes are loosened only to give access for adequate examination of injured parts. Fitness for operation is judged on improved colour, steady pulse and a systolic blood pressure maintained at about 100 mm. Hg. for half-an-hour. Resuscitation is required in the majority of cases only for two to six hours before operation is embarked upon. The Surgical O.C. arranges and writes up on the blackboard an order of operations. He seldom operates himself.

Of casualties admitted 40–50 per cent. come to operation. The average time required for each operation is about an hour, which includes undressing the patient under the anæsthetic and washing off the ingrained dust of collapsed buildings. In eight hours thirty to forty cases can be dealt with by four surgical teams. To work longer than this without relief is to lose efficiency. To delay operations beyond this time is to run increasing risks of sepsis. Thus more than seventy-five casualties should not be admitted by a hospital disposing of four surgical teams.

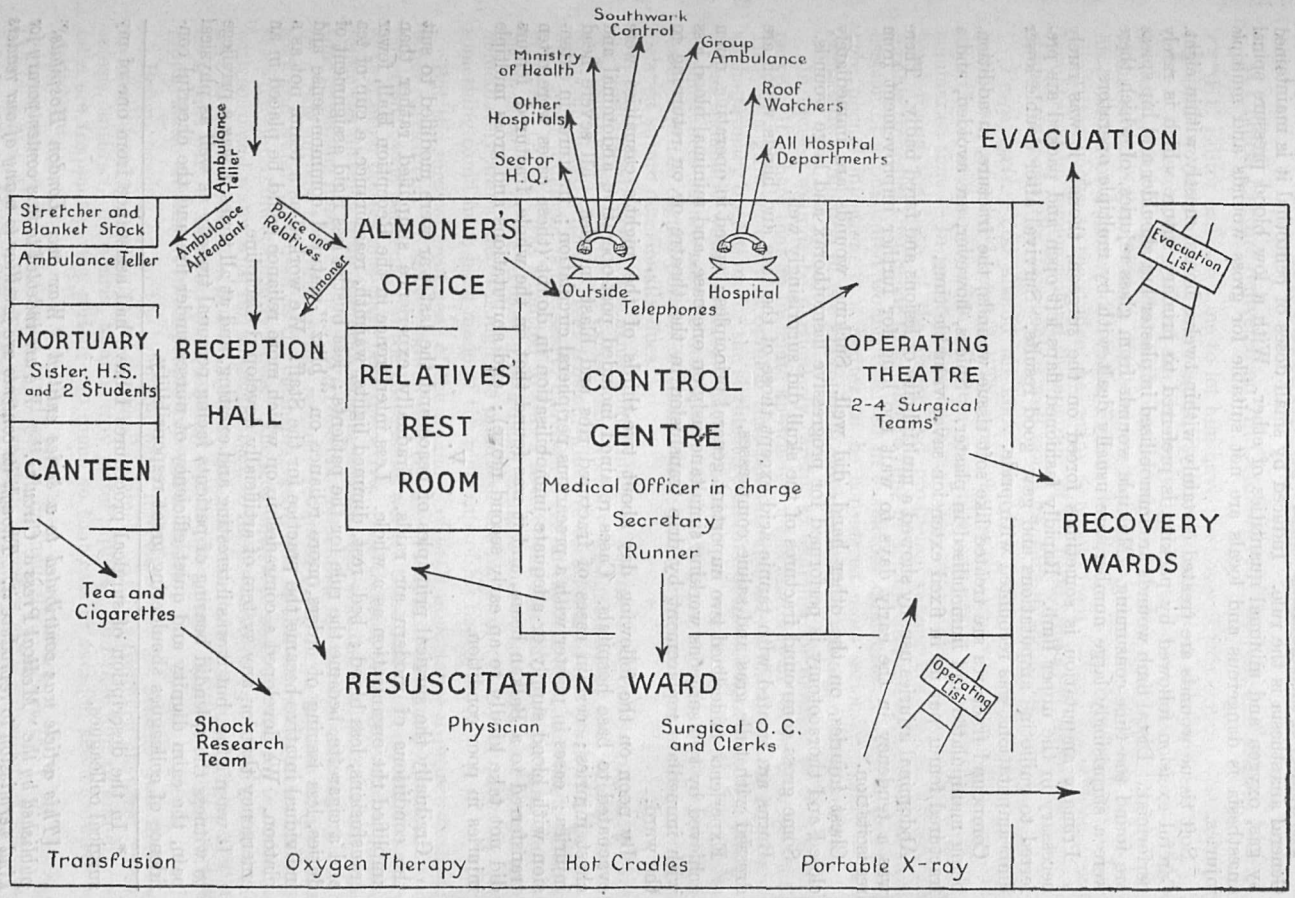


FIG. 2.—Plan for reception and treatment of air raid casualties.

IV*.

The quality of the anæsthetic will in some cases determine life or death of the patient. General anæsthesia is the rule. Induced by small doses of pentothal it is maintained by gas, oxygen and minimal quantities of ether. With a low blood pressure spinal anæsthesia is dangerous and locals are not suitable for gross wounds and multiple injuries.

Soft tissue wounds are treated certainly within twelve hours, mostly within eight. Careful excision followed by packing is preferred to primary suture which is rarely performed. Distal limb wounds are immobilised in plaster but shoulder and hip spicas are found too time-consuming. Multiple wounds from glass injuries, of which there were a surprisingly large number, are usually dealt with by multiple operators.

Primary amputation is sometimes forced on the surgeon, though it was rarely necessary in the upper limb. Rapidly fashioned flaps left open and packed are preferred to guillotine amputations and gave good results. Survival after double lower limb amputations was recounted with pride.

Compound fractures are treated like soft tissue wounds, the fracture, in addition, being manipulated and immobilised in plaster. Spicas, however, are avoided, and a fractured femur put up in fixed extension saves valuable time.

Abdominal injuries usually showed a multiplicity of lesions and fared badly. There was a tendency in the early days to wait too long for further improvement from resuscitation.

Chest injuries, on the other hand, did well. Sucking wounds are immediately closed and thoracotomy is performed for progressive hæmothorax and large wounds.

Some gross compound fractures of the skull did surprisingly well.

Burns are treated with tannic acid except those of the face and hands which are dressed with tulle gras and saline compresses.

Experience underlined two important general principles: speed in operating, often achieved by two surgeons working simultaneously on one case, and minimal blood loss with immediate replacement by drip transfusion in the theatre or on returning to the ward.

By noon on the following day about two-thirds of the night's casualties were evacuated to base hospitals. Cases retained included post-operative abdominal and chest injuries; certain cases of fractured ribs and blast injuries; all severe head injuries; cases in plaster with a precarious peripheral circulation; fractures in extension with blood supply or adequate immobilisation in doubt (these cases were often transferred to a Balkan beam, and it was found that on the whole, fractured femurs did not take kindly to an early second move); and amputations and gross multiple injuries in poor condition.

V.

Gradually the surgical principles of peace and the last war were modified to suit the conditions of modern air raids. Gradually experience simplified rather than amplified the organisation as a whole. Less interference in the Reception Hall, fewer transfusions, less blood; bed, rest, dimmed lights, warmth, reassurance, a cup of tea and a cigarette, became the rule for the patients; less bustle, less rigid assignment of duties, less issuing of orders, more reliance on "blitz"-matured common-sense and individual iniative became the practice for the Staff. We worked as a team, not as a platoon. We developed a comradeship on which more reliance could be placed in an emergency than on any system of artificially developed discipline.

It wasn't fun, but it was interesting and exciting, and at all times it was a privilege to witness the splendid bearing of patients facing personal tragedy as well as physical pain, the calm dignity and quiet efficiency of nurses under fire and the cheerful confidence of colleagues shouldering great responsibility.

---

* In the description of surgical procedures I have had assistance from one of my surgical colleagues.

[*This article was contributed to a series entitled "War over London Hospitals," published by the "Medical Press & Circular." We are indebted to this contemporary for kind permission to reproduce it. Though its contents are familiar to many of our readers and were compiled originally for consumption by a medical public outside the Hospital, we feel that it may be of interest to Guy's men and nurses who were not at the Hospital during the Air Raids of 1940–41.*—EDS.]

Infections of the Hand

A Clinical Lecture delivered on 7th October, 1942, by Nils L. Eckhoff, M.S.

THE Editor has asked me to let him have the notes of this clinical lecture, but in order to save space, I have agreed to let him have it in shortened form.

Infections of the hand are extremely important, for not only do they tend to produce loss of function, loss of limb or loss of life, but they also produce a great deal of unavoidable loss of time. Kanavel was the first to study the subject in detail, and his book is world renowned. Iselin, Fifield, Brickel, Couch and Handfield Jones have all written books, so the student has many to choose from. Wood Jones has recently republished his monograph on the anatomy of the hand, and as all infections must be studied anatomically, this book is well worth its place in the library.

Prophylaxis.—You should all know the correct surgical treatment of wounds, punctured, incised or lacerated. The principles are the same when applied to the hand, and the correct application of these principles can easily be observed. Let me summarise thus :—In punctured wounds make the wound bleed by applying a rubber band round the base of the finger and producing venous congestion. From the terrible tragedies that occur from time to time in doctors and nurses, immediate sterilisation of a punctured wound received in suspicious circumstances, with cautery or pure phenol injection, is a matter to be considered most seriously. Likewise the immediate exhibition of the appropriate sulphonamide if the organism is known.

In incised wounds be particularly careful to examine for damage to tendon and nerve. It is here that an intimate knowledge of the anatomy of the hand is essential. There is a growing body of opinion that tendons and nerves should never be sutured at the primary operation, for the slightest possibility of infection, or even the reaction of the traumatic wound will be sufficient to mar the result. Under the most ideal circumstances suture may be attempted. Suffice it to say that immediate suture of tendons in the digital portion of their course hardly ever produces a movable digit. Delayed suture occasionally does.

In lacerated wounds the same points must be attended to with even greater care. It is usually not possible to excise skin liberally without finding that suture cannot be accomplished without great tension, which in turn leads to the death of more skin. Very great judgment is necessary, but always err on the side of conservatism in hand injuries. (A man was admitted to Guy's to-day who lost all his fingers and some of his metacarpus in the explosion of a hand grenade some weeks ago, and the surgeon immediately amputated through the middle of the forearm. It is very probable that something could have been made of the remnants of his hand.)

But the surgical treatment of the wound is of little importance if proper cleansing is not carried out. Kanavel showed that the use of iodine in one factory reduced hand infections by 38 per cent., but the best results were in those cases that reported at once, so that other factors may have been operative. It is difficult to imagine that any antiseptic (as distinct from bacteriostatic agent) can kill organisms without at the same time damaging human tissues. Who doed not remember the terrible smarting of iodine on a raw surface ? Kerrigan has recently reviewed 9,195 hand injuries where plain soap and water were used as the cleansing agent, and in this enormous series only ten cases developed infection afterwards. The technique is to wash the part for ten minutes with soap and water with full surgical ritual, to flush with saline, and then to hand the part to another team with fresh towels and instruments for the operation. Let us hope that part of our post-war planning will include proper facilities for this sort of prophylactic treatment in all people exposed to injury.

Before passing on to the common hand infections, let me remind you that the specific infections can occur on the hand—namely, syphilis (primary chancre), tuberculosis, anthrax, diphtheria, tetanus (toy pistol injuries), and that human and animal bites are frequently very serious—so much so that careful excision should always be carried out.

Infections of the hand must be classified anatomically. Abhor the term " septic hand," which has no meaning. The five main varieties are : subcuticular whitlow, subcutaneous whitlow, thecal whitlow (or tenosynovitis), subperiosteal or bony whitlow, and paronychia. In addition, special consideration must be given to lymphangitis and septicæmia, and what Koch and Mason call " acutely spreading gangrenous infections."

Apart from occasional carbuncles and boils dorsal infections are rare. I shall consider these varieties in turn.

Subcuticular Whitlow.—This is merely an infected blister and should be treated by immediate evacuation, with removal of the overhanging skin. It is odd how the lesion appears to creep at the edges, so that the following day there may be more loose skin to be removed. Any favourite application can be used, not forgetting sulphanilamide in streptococcal cases. Blisters at the base of the finger must be regarded as serious, for the skin is here so thick that spontaneous evacuation is rarely possible, and the pus tends to burrow deep to the palmar fascia, creating a collar-stud abscess with a deep subcutaneous pocket.

Subcutaneous Whitlow.—This is at once the most common and most dangerous type. It arises in any part of the finger, but most frequently in the pulp over the terminal phalanx. A cross-section of this region shows that the fat is held in compartments by bands of fibrous tissue, which radiate from the bone rather like the setting sun. You all know the intense pain which accompanies the development of such an infection. This is largely due to the fact that great tension is produced in these tiny compartments. In time the pus travels to the next compartment and so on. The advance is slow yet steady. The common application of moist heat at this stage is dangerous, for in a short time the patient is unable to distinguish between the pain of the lesion and the pain of the treatment. Dry heat is less liable to extremes and is soothing, but must not be allowed to mask the progress of the condition. The cessation of pain is the worst sign, for this usually means death of some part or other of the digit concerned.

Intense localised pain is nearly always an indication of localised pus, which had better be evacuated. It is advisable to examine the finger point by point with a blunt instrument, and to mark with ink the exact location of the pain. At this stage a small incision, properly placed, will often open a small loculus and the condition is cured. Remember again that the operation is to be performed with full surgical ritual, with complete anæsthesia and a tourniquet. It is no " cut and run " operation, but a slow carefully planned dissection. How many cases do we see that have had one, two or three " lancings " under local anæsthesia, so called, without the dermis being penetrated at all.

I feel it is not my duty to describe the finger which is a " bag of pus," for it is not surgery to operate on such, and such cases should never be seen. They indicate criminal neglect. But I must tell you that allowing a finger to progress to this condition inevitably invites necrosis of bone, involvement of tendon sheaths and joints, and spread into those potential spaces in the palm which are now so well known. Necrosis is common in the distal phalanx, for very little increase of tension will destroy the blood supply. Involvement of tendon sheath occurs when the pus reaches the middle phalanx and, when the proximal phalanx is reached, pus spreads into the thenar or middle palmar space *via* the sheath of the lumbrical muscle. The anatomy of these spaces you ought to know. Involvement is diagnosed by loss of palmar hollow and tenderness over the space. The incision for the thenar space is made either in the thumb web or on the dorsum along the radial side of the second metacarpal (passing the forceps through the first dorsal interosseous muscle), while that for the middle palmar space is an upward extension of the incision along the side of the finger to the web, where the forceps can be passed along the lumbrical sheath, deep to the long flexor tendons into the space.

Incisions on a digit should never be placed ventrally because :—(1) A ventral incision is much more likely to endanger the tendon sheath, or allow prolapse of the tendon if the sheath must be incised ; (2) a ventral incision is not so likely to strike across the fibrous bands between loculi ; and (3) a ventral incision always leads to contracture of the finger.

Thecal Whitlow.—Suppurative tenosynovitis may be a complication of a subcutaneous whitlow improperly treated, when the outlook is poor and amputation often follows, or it may occur as a primary infection of a tendon sheath. Here early diagnosis is vital. You must remember that the tendon sheaths of the index, middle and ring fingers extend from the base of the terminal phalanx to a point in front of the metacarpophalangeal joints or three-quarters of an inch proximal to the web ; that the fibrous part of the sheath is especially thickened opposite the proximal and middle phalanges, so that when the synovial part is distended it will bulge more particularly at the proximal end and opposite the creases ; this is the obvious place to make incisions for drainage ; that the sheath of the thumb runs upwards to a point well above the wrist joint and is somewhat dilated to form the " radial bursa," while the sheath of the

little finger runs up to the same point, and is dilated in the palm to include the deep flexor tendons, and is usually called the " ulnar bursa " ; that the radial and the ulnar bursæ often communicate. Thus you will see that an infection of the thumb or little finger tendon is a very serious matter, and will usually have to be drained by incisions opposite the creases of the thumb and little finger, and by incisions above the wrist on the radial and ulnar sides. I have seen two cases recently in old women, both from picking roses : in each the thumb became gangrenous at the tip (a thing that not infrequently happens in infections) and the infection thus easily spread to the sheath ; both were brought to me rather late ; both had secondary hæmorrhage ; one died and the other had to have her hand amputated. I have also seen early cases where the appropriate incisions have led to rapid resolution of the condition, with complete restoration of function.

Tenosynovitis is diagnosed by four cardinal signs, in this order :—(1) Uniform swelling of the whole finger ; (2) finger kept in the position of flexion ; (3) exquisite tenderness over the sheath, especially at its upper end ; and (4) pain on movement, especially passive extension.

Diagnosis is easily established. Treatment is immediate operation. Some books describe long incisions splitting open the whole sheath. This almost always leads to prolapse and sloughing of the tendon and ruination of the finger. Short incisions opposite the flexion creases, opening the sheath on each side, paying particular attention to the proximal end in the palm, where a rubber drain can well be passed through the hand from front to back, with incisions above the wrist in the case of thumb and little finger infections, should be quite adequate and, if not too long delayed, should give quite a fair chance of a movable digit afterwards.

Subperiosteal or Bony Whitlow.—The bone is frequently involved in neglected whitlows of the pulp of the finger, in advanced whitlows of the more proximal parts of the finger, in advanced tenosynovitis, in direct injuries (compound fractures), and occasionally in acute osteomyelitis. Except in primary osteomyelitis the treatment is conservative, and operations are only done to drain subperiosteal abscesses or for the removal of sequestra which are loose. Here let me mention joint infections, which are often primary lesions in those patients who receive an injury over the knuckles. Like bone infections the condition is chronic and no good will come of premature surgery. Ankylosis is to be anticipated and the hand placed in the position of function, but when the first interphalangeal joint is involved in a working-man, primary amputation of the finger is the best method of treatment, for the patient will not thank you for a stiff finger after many months of suppuration.

Paronychia.—This is an infection round the base of the nail, graphically called a " run around " in America. It is easily diagnosed. If left, pus will exude under the eponychium, and may continue to do so for weeks. The correct treatment is *not* removal of the nail. It must be realised that the pus lies between the nail and the *proximal* part of the nail bed. It is, therefore, only necessary to remove the proximal part of the nail, but first a little flap must be turned back by making two incisions backwards from each edge of the nail, being careful not to incise the nail bed. This gives free drainage to the diseased part, and a little wisp of vaselined gauze left in place for forty-eight hours allows healing in ten to fourteen days.

In four of the five lesions I have described early surgery is indicated. This is certainly not the case in the condition I have yet to describe. Mistakes are often made in both directions, but there should be no real reason for this.

Lymphangitis is easily recognised. In this condition red lines are seen running up the arm in most instances. In some cases pain is felt in the axillary glands even before the lines are seen on the arm and certainly before the glands are obviously enlarged. In some the lines may not be clearly marked, but the whole picture is that of a diffuse infection (a cellulitis), rapidly spreading and showing no localised point of tenderness ; in fact, if surgery is contemplated, it is impossible for the surgeon, thinking anatomically, to know where to make his incision. Under such circumstances an incision had much better not be made. Incision in these cases is only likely to spread the infection, and I recently saw a case where the patient lost the three phalanges of her index finger after a doctor had made an incision over the distal phalanx and was surprised not to find pus.

These are also the cases that are likely to develop a clear-cut septicæmia, or pyæmia, with secondary lesions. I have seen pyæmic arthritis of the knee, shoulder and wrist, and secondary abscesses in all parts of the body from cases of this sort.

Diffusely spreading gangrenous infections are severe instances of the same sort. They fall into four groups :—(1) Those in whom the infection spreads rapidly up the arm, then subsides completely ; (2) those in whom the infection spreads up the arm, then subsides, and leaves a local abscess at the periphery ; (3) those in whom the infection spreads up the arm, then subsides, and leaves an axillary abscess (which may take months to clear up) ; and (4) those in whom the infection spreads rapidly up the arm, to the supraclavicular region and onwards, leading to death in twenty-four to forty-eight hours.

In the cases mentioned in the above two sections the correct treatment is to put the patient to bed (all hand infections should be hospitalised), treat the fever on general lines, using sulphonamides if indicated, place the arm on a splint from the axilla to the tips of the fingers, and apply large hot compresses over the same area. Only at a much later date should abscesses be treated as they arise.

Carbuncles and *boils* occur on the dorsum of the hand at times, and should be treated conservatively. Rest is essential, short-wave diathermy seems to help, cupping is used by some, and good reports are given of the injection of antistaphylococcal serum into the buttock, but I have been disappointed with its use. Dorsal infections are otherwise rare, and you must be careful not to be led into incising the back of the hand merely because it is swollen. Oedema is present here in most cases of palmar infection, and is due to the fact that the lymphatics pass through the loose cellular tissue on the dorsum of the hand on their way from the palmar surface to the forearm.

I have indicated as far as possible the local treatment of each type of hand infection. The general treatment of the patient is very important, too. All cases should be treated in bed at first, with the arm on a splint. In localised infections incision should bring immediate relief. Hot wet dressings have been criticised in the pre-operative treatment and are equally undesirable in the post-operative period. They should be unnecessary as a palliative if the incisions are correct, and are only likely to confuse the issue if this is not so. Furthermore, they tend to prolong the œdema which is such a disturbing feature of all hand injuries and infections. Hot baths have the same bad faults. Frequent dressings in any form are undesirable owing to the risk of further infection. There is a lot to be said for wrapping up the hand in the position of function, with the forearm elevated vertically, and leaving the dressing for several days, if the general signs are satisfactory and pain is absent.

Correspondence

NURSES AND RUSHCLIFF REPORT.

To the Editor of the GAZETTE.

SIR,—The last issue of the *Gazette* contained a letter claiming to be the nurses' point of view of the Rushcliffe Report. May I please be permitted to dispel any illusion that the sentiments expressed in that letter are shared by all Guy's nurses ?

The Rushcliffe Report is to be welcomed as an attempt to standardise nurses' conditions of service, but its recommendations are much more limited than appears at first sight. Although the national salary scales, the shorter working hours and longer holidays will be appreciated, it is necessary to point out that these factors cannot be isolated from the causes of failure to attract sufficient recruits to the nursing profession.

The too rigorous and unnecessary discipline, the restrictions on the nurses' personal freedom, and the compulsory living-in system are all contributing causes to be considered, and the profession will fail to attract enough recruits until these causes are removed.

A committee can only recommend certain improvements in a profession. The regularising of conditions of work and the setting up of negotiating machinery for dealing with the employers must be the responsibility of the members of the profession, and until nurses interest themselves in improving their own conditions, and thus helping to increase the efficiency of the nursing services, there can be no hope of attracting sufficient numbers of intelligent girls who will make good nurses.

Regarding salaries, *The Lancet* Report of 1932 definitely exploded the theory that student nurses are a burden on a hospital, and established the truth that, by giving labour of a more skilled type than that for which they are paid, they are, in fact, benefiting the hospital. Otherwise, how is it explained that almost all hospitals seek to establish training schools for nurses. The introduction of the block system should not affect salaries either way, as it would not entail any decrease in the amount of work done in the wards.

The people who advocate very low salaries for nurses in training would seem to be trying to close the profession to all but those girls who can rely on financial support from home. Obviously this is no way to ensure an increased flow of recruits to one of the most vital sections of the health services.

Yours, etc.,

Nurses' Home, Guy's Hospital, S.E.1. MARY D. GOODMAN.

PICTURES OF DISEASE.

To the Editor of the GAZETTE.

SIR,—Mr. Clive Sharp's letter on "Pictures of Disease" points to what has always been a defect in the teaching of medicine—but its suggestions are not new.

I recommend him and all others who are interested to visit the Wellcome Museum, where he will find an admirable display on the lines he mentions, which was originated more than twenty years ago on a system devised—as far as my memory serves me—by Dr. Daukes, author of the "Barrier Charts," which I recommended in one of the early "Letters to My Nephew." It is a model for all "teaching" museums, but applies mainly to tropical diseases.

Yours, etc.,

"UNCLE HARRY."

Rugby

ON February 27th, Guy's entertained ALDERSHOT SERVICES at Honor Oak Park, and had no difficulty in winning by 2 goals, 1 penalty goal and 2 tries (19 points) to a try (3 points).

Batty-Shaw returned to the side in place of Hilliam, and, as Willcock and Brittain could not play, Vann and Kinder deputised.

Guy's missed a golden opportunity of piling up a big score. They had practically all the play during the first half, scoring 16 points without reply. On the resumption, the Services took a man out of the pack, obviously for defensive purposes, but, to everybody's amazement, Guy's did likewise, and, as a result, lost their advantage in the set scrums and line-outs, the three-quarter movements were cramped, and when Lewis also came into the attack the six "*three-quarters*" had no room to manœuvre.

Brangwin was in excellent form and sent Albers over the line, but he lost the ball, and Harvey, lying handy, touched down for Lewis to convert. Harvey's excellent backing up brought him another try when he took a pass from Strathie, who had broken clean through the opposition, and this was followed by Wilshere and Brangwin scoring, the latter from a brilliant solo run, Lewis converting another try.

The second half was terribly scrappy; play deteriorated until Guy's were reduced to their opponents' level. Farrar scored a well-deserved try for the Services, and Lewis kicked a penalty goal for Guy's.

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, P. L. Brangwin, D. M. Strathie (captain), J. N. Micklem; W. H. Lillywhite, R. N. H. Vann; A. Batty-Shaw, A. B. Lee, L. H. Hilliam, A. G. Albers, D. L. Gullick, P. D. Harvey, C. Vidot, B. H. Wilshere.

C.H. KINDER.

The visit of ST. MARY'S to Honor Oak on March 6th was considered the best fixture in Town, and right well did the players live up to their reputations. Although Mary's thoroughly deserved their victory, the margin, 1 goal and 2 tries (11 points) to nil, was somewhat flattering, and only their opportunism in taking advantage of poor positioning and an intercepted pass, enabled them to score.

Guy's fielded their strongest side with Brittain returning in place of Kinder, and he was about the best all-round forward on the field. The forwards were marvellous, especially impressive was Lee's hooking, Vidot's line-out work, Batty-Shaw, Wilshere and Harvey in the loose, Albers and Gullick in the tight, and their tackling was superb.

Lillywhite's kicking was very accurate, but with little support did not quite succeed in keeping Kemp in check, which is two men's job. Willcock is a plucky and skilful little player, but frequently ran into trouble when trying to barge through a ruck of forwards. Strathie was constantly manœuvring for openings, and gave the Mary's defence some anxious moments, but, even so, most of the three-quarter movements were halted in the centre, and with Lewis occasionally coming into the attack, Macrae-Gibson had about one good pass all afternoon when he made good use of the cross-kick. Brangwin was always endeavouring to send Micklem through and the latter might

have scored had he kept his speed, weave and swerve going on approaching an opponent. Lewis's fielding of the ball and long touch-kicking was of the highest class.

Guy's actually had slightly the better of a pointless first half territorially, but soon after the interval bad positioning enabled Mary's three-quarters to swing the ball from one side of the field to the other, where Graham crossed for Watson to convert. Bad positioning was again responsible for the second try, when Morris was quick to seize the chance to send Peart away on the blind side from a scrum just inside Guy's "25," and the final score came as a result of a faulty Guy's pass on the half-way line, which Graham intercepted to send Scott over. It was the extra bit of polish in the Mary's back division which turned the scales in their favour.

Guy's took a strange team to BEDFORD on March 13th, with no fewer than five changes from the side that met Mary's. Harris, N. K. Macrae-Gibson, J. S. Ebsworth, Vann and Hilton coming in for Lewis, Brangwin, Llilywhite, Willcock and Brittain respectively. Nevertheless, Guy's put up quite a creditable performance and were only beaten by a penalty goal and 2 tries to a dropped goal, 9 points to 4, after having a fair share of the game.

Bedford, with McMasters hooking, had more of the ball in the back division, but Guy's defended stubbornly, although they took a long time to settle down. Perhaps, the late arrival of three players soon after the game had commenced was responsible for this. The forwards have been the backbone of the side the whole season, but in this game they showed a tendency to stop when an opponent knocked-on or gave a forward pass, and thus, by not playing to the whistle, lost the advantage which might have led to a score. Also, they were somewhat slow in recovering and getting their feet over the ball in the loose, which enabled the Bedford forwards to press home their attacks. Vann played very well at the base of the scrum, and Ebsworth tried to keep the play open, but the backs must bring their man down when going into a tackle. One seldom sees a cross-kick from the wing three-quarters these days, which is a pity, because Guy's have some fast forwards, well able to get up quickly and, if not actually scoring themselves, have the ability to keep the play open for the backs.

With two men short Guy's gave away a penalty kick soon after the game started and Vasey kicked a goal. Following this, Guy's were at full strength but Bedford continued to have the best of the game and Hay crossed for an unconverted try. This inspired Guy's and Bedford were compelled to defend for some time, but Ebsworth found himself in the position to drop one of his famous drop-goals, and might have had another with a bit of luck. He makes a practice of this in the "A" XV.

Guy's must be congratulated on the manner they prevented Bedford from scoring during a long period of second half pressure, and, indeed, when Guy's took up the attack, with a little luck might have scored, but Bedford managed to touch down twice in quick succession. Play was now more even, but bad tackling and marking enabled Knight to run in for a try for Bedford.

One word about N. K. Macrae-Gibson; he frequently beats his man and gets clean away, but somehow or other runs right into a defender before passing out, or fails to time his pass to the advantage of his side. He has the skill but just does not seem to make the top grade, where many good judges feel convinced he belongs.

Hospital Information, etc.

Awards

Royal Red Cross (*1st Class.*)
Miss Muriel May Masters (Q.A.I.M.N.S.).

Change of Address

R. O. Yerbury, Major, I.M.S., c/o Lloyds Bank Ltd., Bombay.
G. V. L. Williams, Major, D.A.D.D.S. (87714), H.Q. Bone Area, B.N. African Forces.

Births

YERBURY.—At Ootacamund, India, to Mollie (née Dunn), wife of Major R. O. Yerbury, Indian Medical Service—a daughter. Letters: c/o Lloyds Bank, Ltd., Bombay.

Deaths

GIRLING.—On February 20th, 1943, Charles John Girling, M.B., at Stratford-on-Avon.

PONSONBY.—On February 6th, 1943, John Ponsonby, L.R.C.P. (Lond.), of Newland Avenue, Hull.

SWAN.—On March 2nd, 1943, in London, R. H. Jocelyn Swan, O.B.E., M.S., F.R.C.S., of 75, Wimpole Street, W.1.

EDS. { P.F.E.B. J.O.L.

GUY'S HOSPITAL GAZETTE

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PASSIM

WELL, it's Spring again on the calendar, as in fact the weather of a fortnight ago would have suggested then, the present weather not being a printable matter, in one way at least. And, with everyone waking from their winter somnolence, reform is in the air. Plans for the future are being tossed about with a careless abandon that sometimes makes one wonder this plan is accepted, that one rejected, and *vice versa* next week. One newcomer to the list has been generally welcomed—the joint committee of the Ministry of Health and the various medical organisations, set up to correlate, as far as this may prove possible, the ideas of post-war medicine which have been put forward. An old friend, still going strong when last heard of, is the committee on medical schools; and another, the Rushcliffe committee on nursing matters has just reported. This last has stirred up some healthy controversy in these columns, which continues in this issue. As is to be expected, the Nursing Staff itself is the main participator, but it is to be hoped that it is not entirely ignored by the rest of the readers of the *Gazette*, who will, in the long run, feel its effects in a very practical way. There is no more important matter in the efficient running of a hospital than the attitude of the nurses, and their attitude is largely influenced by the appreciation of their work, shown by the treatment they themselves receive.

We must have all been impressed by the report on the nation's health for the last year that has just been issued, and it is indeed good to know that in general we are fitter than ever. But from our point of view this is nothing like so important as the rider that was added, to the effect that venereal disease in particular is very much on the increase and that the tuberculosis situation is far from satisfactory. The Government campaign against venereal disease is only just starting and we must give it time to develop. As we noted in these columns some weeks ago, some very good pamphlets on the subject have been issued by the Ministry of Health in conjunction with the Central Council for Health Education, and if that standard is kept up so well and good. As for the workings of 33B, perhaps we had better not say too much, but it must be obvious to all that it is by no means unanimously approved by those who are best qualified to know. Which points the moral, as all sermons and "Passims" point morals, that it is more than ever necessary now for us to put forward and hold to suggestions for action based on our knowledge of medical matters. It is only too obvious sometimes that the suggestion, based on sound medical principles, that has started some scheme has later been quite overlaid and nullified by non-medical persons, who have failed to appreciate the point. If we are to get anywhere in medical legislation it is no good getting fed up with what is, very comprehensively, termed politics, as is the tendency of all non-politicians who get mixed up in them. Whether we like it or not, we must stick to our ideas, and in those where we alone can truly judge the effects, we must not be content with half a loaf.

Turning to matters nearer home we are now getting more horticultural than ever. The site of the East Wing of the Front Quadrangle is now under the influence of our Matron and her workers, and presents both serried rows of vegetables and also a greenhouse. The park, with Miss Addiscott's flower beds, is showing the results of a hard winter's work.

IMPORTANT.—Paper-saving flash! It is essential that we should save paper as far as possible, and this goes for the *Gazette*, too. We are trying to avoid waste of copies, so if you don't keep your copy permanently, will you share one with someone else or, if you prefer, read yours quickly and then return it to the office you got it from for further circulation.

Clinical Aspects of Tobacco Smoking

By T. L. HARDY, M.D., F.R.C.P.,
Honorary Physician, Birmingham United Hospital.

A Paper based on remarks made in opening a discussion at Guy's Hospital on Friday, December 4th, 1942.

MAN, primitive and civilised, has always shown himself markedly adroit in finding those things which produce a stimulating or soothing effect on his nervous system—things, which though not physiologically necessary for his continued existence, appear to add something to life's contentment. We have thus accustomed ourselves to the routine use of certain substances of pharmacological potency, particularly those adjuncts to good living—tea, coffee, alcohol and tobacco.

Throughout its four hundred years of history opinion has been divided, often very sharply, as to the merits of tobacco smoking; some in their moment of ecstasy regarding it as a heaven-sent blessing—Burton's "divine tobacco," Byron's "sublime tobacco," Oliver Wendel Holmes' "great vegetable"; while others, notably James I, have seen its origin in a very different quarter, regarding it as hellish, devilish and damned. But gradually as the habit of smoking has increased, so the noise of controversy has been stilled and opinion, including much medical opinion, has been lulled to a condition bordering on dangerous apathy. Widespread experience shows that in the opinion of vast numbers of human beings moderate usage, if measurably deleterious at all, is not so immediately and strikingly harmful as to weigh seriously against the pleasures to be derived from its indulgence. This opinion may be correct, and perhaps would be if we were able to define with any sort of precision or agreement the term "moderate usage." But this we cannot do, and as doctors and potential doctors we must surely view not with indifference, but rather with some apprehension, the great increase in smoking which began with the last war and has been gathering momentum ever since, so that a habit which was formerly regarded as a luxury has too often become for many a necessity. The medical aspects of smoking must interest us all in our present and future capacities as the medical advisors of others, and especially I think it should interest medical students, whose habits are presumably in a formative stage and whose opinions are still reasonably free from that prejudice which is apt to colour the views of more hardened sinners.

The chemical composition of tobacco smoke is complex, but there are three substances which have always been regarded as responsible for most of the unfavourable effects of smoking—the alkaloid nicotine, the pyridine bases and carbon monoxide. Of carbon monoxide I think it may now be said that its effects, formerly regarded as of some importance, are really negligible. According to recent experiments carried out by the United States Bureau of Mines, smoking under intensive conditions and in a vitiated atmosphere does not increase the carbon monoxide saturation of the air of the room by more than 1/100 per cent., and the maximum blood saturation of the subjects was 5 per cent., quantities that are negligible.

The pyridine bases, collidine and lutidine, are oily, volatile liquids of comparatively low toxicity and intensely irritant. They are not peculiar to tobacco smoke, but are emitted from any smouldering vegetable matter. They add nothing to the pleasures of smoking, and are responsible for the irritation of the mucous surfaces of the mouth, throat and the upper air passages. The angry looking, fiery appearance of the throat, pharynx and larynx in people who smoke to excess, especially cigarette smokers, is very characteristic, and such results as morning cough, air swallowing, retching and vomiting may be directly attributable to the presence of these substances. When a patient complains of morning vomiting, enquiries into his habits as regards tobacco, and a look at his naso-pharynx, are often more fruitful than an inquisition into his alcoholic indulgences. With the passage of years chronic cough produces effects on the lungs and on the heart which are certainly not negligible.

A more serious effect of the pyridine bases is tobacco amblyopia, a rare form of blindness with considerable impairment of central vision. The volatile products of tobacco are said to damage the ganglion cells of the fovea and macular regions. It affects men of between thirty-five and fifty-five years who have been hard smokers for twenty or more years before the appearance of symptoms. Recovery usually takes place if the habit is given up completely and forthwith.

The alkaloid nicotine was first isolated by the French chemist, Vauquelin, in 1809. He gave it the name of "nicotine" after Jean Nicot, who was private secretary to the King of France, and later Ambassador to the Court at Lisbon in 1559. Here he obtained cuttings of the tobacco plant and cultivated them in the Embassy grounds. He had considerable success in the treatment of wounds and ulcers by the external application of tobacco leaves. Nicot knew nothing whatever of the habit of smoking, which was only introduced from England at a later date, so he can hardly be said to deserve the perpetuation of his name in the alkaloid. Nicotine is by far the most important constituent of tobacco smoke, and is said to be responsible for most of its effects, pleasurable and otherwise. It exists in tobacco in combination with organic acids. During smoking these salts are largely dissociated, part of the nicotine being burnt and passing into the smoke as free nicotine. Tobacco leaf may contain anything from 1–8 per cent., but the drier the tobacco the more complete the combustion and the greater the destruction of the nicotine. In the slow combustion of a cigar or pipe, as in normal smoking, there is an area immediately behind the point of combustion in which water and other volatile substances condense. During aspiration the hot gases are drawn into this area and carry with them the volatile principles, including nicotine. Hence, the smaller this moist area, which means the drier the tobacco and the more complete the combustion, the less likely is smoke to contain toxic bodies. Thus, a cigarette or a long, slender cigar will yield less nicotine than a thick cigar, while the unpleasant effects of relighting an unfinished pipe or cigar are similarly to be explained. Moist tobacco thus produces much more serious effects than dry tobacco, the water content being more harmful to the smoker than the original content of nicotine. The amount of nicotine absorbed depends on a variety of factors, such as the rate of smoking, the amount of tobacco used, the moisture of the tobacco, the degree of inhalation, and the length of time the smoke is held in the mouth. The late Professor Dixon, of Cambridge, amongst whose many claims to fame was an ability to extricate humour even from lectures on pharmacology, found by experiment that of three-quarters of a standard Virginian cigarette, three milligrammes were absorbed. All of this will not get into the system, but in the case of inhalers at least three-quarters will, since, as we no longer expectorate, escape can occur through the exhaled smoke only. Thus, if a cigarette smoker were to smoke ten cigarettes on end, he would certainly absorb twenty to thirty milligrammes, and this, though far below the lethal dose, would be sufficient to produce profound physiological effects.

A word now as to the pharmacological action of nicotine. It is one of the most fatal and rapid poisons known to science, being comparable in its toxicity to prussic acid. Calverley was not drawing on poetic licence when he wrote :—

> "How one or two at most
> Drops make a cat a ghost;
> Useless except to roast.
> Doctors have said it."

The lethal dose for a man is from 60 to 120 milligrammes, while the amount of nicotine present in one cigar, if injected intravenously, would represent two fatal doses. Tobacco is readily absorbed from the unbroken skin, as well as from the mucous membrane. It no longer finds a place in therapeutics, but cases of fatal poisoning have been recorded in the past through its careless use in treatment, both as an external application and internally as an enema to promote a certain degree of relaxation and narcosis before the days of anæsthetics. In a recent number of the *British Medical Journal* acute poisoning with abdominal pain, vomiting, constipation and collapse is recorded in the case of two gardeners from the use of a liquid insecticide containing 3.7 per cent. of nicotine. Both men neglected the caution, printed on the tin, to wear rubber gloves. There is also on record the distressing situation of a convict who hid an ounce of cavendish tobacco in his rectum, and though he successfully carried it past the warders, failed to recover it at the appropriate time and suffered acute poisoning in consequence.

Nicotine stimulates all cells throughout the body without exerting any kind of selective action. This effect lasts throughout the period of active smoking and is followed by a period of depression. It thus differs from other alkaloids such as morphine, heroin and cocaine, which have a selective action on the central nervous system only; nicotine acts also, as Langley showed, on the autonomic nervous system, both sympathetic and parasympathetic, first stimulating and finally paralysing the junction between the connector fibres and the excitor cells. It is this action which is responsible for most of the objectionable features in sensitive or excessive smokers.

TOXIC EFFECTS.

Heart and Circulation.—The results of smoking upon cardiac efficiency may be divided roughly into two groups: those which give rise to temporary inconvenience and are without serious significance, and those which may cause, aggravate or simulate grave cardiac disease. In the former group we have to consider disturbances of rate and rhythm and, in the latter, disease of the coronary arteries and angina pectoris. It is a well-recognised fact that the use of tobacco causes a rise of the pulse rate of from five to ten beats per minute, an effect which comes on within a few minutes and lasts throughout the period of smoking. It occurs in the moderate smoker as well as the novice, causes no inconvenience, and does not, as a rule, interfere with the normal response to effort. On the other hand, in those in whom the heart's action is unduly irritable, as, for example, in the condition known as the effort syndrome, this rise of pulse rate after smoking was shown by Parkinson to be slightly more marked, the rate after exercise maintained at a higher level, and there was more breathlessness. He concluded that though tobacco did not cause the symptoms, it was undoubtedly an aggravating factor. Palpitation, rapid action and extra systoles are frequent effects of smoking in the young and tend to disappear as tolerance is established, to reappear in later life when tolerance is often diminished, extra systoles more common and more easily induced.

With regard to grave forms of cardiac disease, and especially angina pectoris, it has now been established, I think beyond doubt, that true angina cannot be caused solely by tobacco, and that the old terms "tobacco angina" and "tobacco heart" are misnomers. It is equally beyond dispute that tobacco-smoking to excess, or in sensitive persons, and especially in the form of cigars, can precipitate attacks of angina in those predisposed to them by coronary artery disease. In this connection it is interesting to note that most recent workers have failed to produce by perfusion experiments constriction of the coronary vessels, such as is generally held to be the cause of the attacks. On the contrary, both in the isolated rabbit's heart perfused with infusions of tobacco, and in heart-lung preparations in dogs when tobacco was introduced into the pulmonary alveoli, the result was an increase in the blood flow through the coronary circulation. The explanation of anginal attacks from smoking appears to lie in the increased work of the heart, as shown by an increase in pulse rate and some increase in blood pressure. Thus, with a lessened diastolic filling of the coronary arteries, the effect on a heart muscle already poorly supplied with blood owing to coronary disease, will be the same as exertion and may result in an anginal attack.

Tobacco has ranked prominently among the numerous causes said to give rise to arterial hypertension, and many have laid aside their pipes, and declined the proffered cigar with becoming resolution on medical advice because of a high blood pressure. Nevertheless, there is no convincing evidence that smoking contributes anything at all to the production of hypertension. The immediate effect of smoking on individuals is variable. In the novice there may be a rise of from 20 to 25 millimetres of mercury lasting throughout the period of smoking. In habitual smokers the rise in pressure amounts to no more than a few millimetres of mercury, and it may be absent. Despite such transitory effects the majority of habitual smokers, and even excessive smokers, have blood pressures well within normal range and, as Broadbent pointed out, in some instances the pressure level may be even low.

If their is no proof that tobacco contributes to the development of a high blood pressure, neither is there any evidence that it can produce arterial degeneration. In the disease of the arteries known as thrombo-angeitis obliterans, originally described by Louis Buerger in 1908, in which the blood supply to the extremities is slowly cut off, leading first to intermittent pain on walking, the so-called angina cruris, and later to gangrene, there is a high proportion of excessive smokers among its victims. A well-known physician, on his retirement, passed his leisure time in fishing and in growing tobacco. It was his habit to pick and smoke the moist green leaf, until, unhappily, he developed Buerger's disease and had to suffer amputation of one leg. There is, however, no sound experimental evidence that nicotine alone can cause arterial degeneration, and Thienes and Butt, of Los Angeles, in 1938, using rabbits and rats as their experimental animals, found a higher proportion of vascular degeneration in the control animals than in those chronically poisoned with nicotine. The role of tobacco in arterial disease is doubtless due to its vaso-constrictor effect, which on the peripheral vessels, in contradistinction to the coronary arteries, has been demonstrated by studies of organ volume, skin temperature, and blood flow before, during, and after smoking. Modern evidence, then, has done nothing to disturb the opinion expressed

many years ago by that distinguished physician, Sir Clifford Allbutt, who, from a vast clinical experience, wrote " that the effects of tobacco on arteriosclerosis, high blood pressure and senile atheroma are negligible."

The Alimentary Canal.—I do not propose to discuss here the minor degrees of inflammation which the irritant properties of tobacco smoke cause in the mouth, except to mention salivation, which is a very constant effect of smoking and may lead to the swallowing of considerable amounts of nicotine. This, in its turn, may produce gastritis and possibly explain those rare cases of indigestion sometimes called " tobacco dyspepsia." Professor Ryle, in his well-known classification of the dyspepsias, suggested some years ago that the effects of tobacco, heartburn, fullness after food, and even hunger pain, were probably due to inhibition of the sympathetic supply to the stomach, followed by overaction of the vagus in susceptible individuals ; and the effects on the alimentary canal in general are of this type—namely, pressor effects. In a few instances, the symptoms of tobbacco dyspepsia mimic with great fidelity those associated with duodenal ulcer, so that the late Lord Moynihan was wont to speak of the " tobacco ulcer."

In duodenal ulcer a relationship to excessive smoking has long been recognised. A large majority of ulcer patients—my own figures are in the region of 75 per cent.—are heavy smokers, and it was at one time thought that this might, in part, account for the preponderance of the disease in males, the sex incidence being about four to one. However, it was shown by the late Professor Wilkie, of Edinburgh, that of eighty-four women whom he had operated on for duodenal ulcer, 80 per cent. were non-smokers, and the difference in sex distribution is to be sought rather in certain physical and psychological characteristics which the great majority of male ulcer patients present. Tobacco is one of the many aggravating causes of ulcer symptoms in susceptible individuals, and the majority are generally able to recognise that they are freer from indigestion if they do not smoke, and that excessive smoking will often bring about a recurrence of the illness. The explanation of this well-attested clinical observation has yet to be found. The hunger contractions of the empty stomach are very rapidly abolished by smoking, and this may account, in part, for the loss of appetite, an effect which should preclude the use of tobacco before meals. Observations on gastric secretion by means of test meals, and on the emptying rate of the stomach after varying meals, have been few in number and discordant in results. The most comprehensive study that I am aware of, was one recently undertaken by Ivy, of Chicago, in the hope, to use his own words, " that by some simple test of gastric function, it would be possible, in patients with duodenal ulcer, to pick out those who responded unfavourably to tobacco." This hope was not fulfilled. He made observations on sixty subjects—twenty-five smokers, fifteen non-smokers and twenty patients with duodenal ulcer. Using the fractional test meal he made observations on the fasting secretion, the resting secretion and the response to food, over a period of two hours, during which from four to seven cigarettes were smoked. There was no significant change in the amount of fasting secretion or in the acid values of any of the three groups during the experiment. Similarly, by recovering the residual juice Ivy found no significant alteration in the time of evacuation. He emphasised the difficulties that are inherent in human experiments of this kind ; that the degree of tolerancei is subject to great variation ; that the pleasure and restful euphoria produced in indivduals by smoking may actually favour digestion so long as the limits of tolerance are not too closely approached ; and, finally, that in any particular individual the function of one bodily system may be more affected than another.

On the colon tobacco is found by many to have a useful laxative effect. There is here, of course, a possibility of a conditioned reflex, quite apart from tobacco, but Ivy was able to show, as a result of experiments on twenty medical students, ten smokers and ten non-smokers, selected for the stability of their bowel habits, and observed under constant conditions of diet, that smoking tended to produce some augmentation of colon activity. In patients with irritability of the colon, and a tendency to colon spasm, leading sometimes to constipation and sometimes to diarrhœa, tobacco is certainly an aggravating factor and should be avoided. As to whether that laxity of the bowels, so frequently associated with an impending examination, is to be attributed to a well-merited apprehension as to the results, or to an increased refuge in tobacco to remove the apprehension, I must leave my readers to decide.

By way of illustration of some of the clinical effects of oversmoking, I cannot do better than quote in full an account I have recently received from a patient of Sir Arthur Hurst's, a colonel in the Army Medical Service. He writes :—

" I am aged fifty-one ; A 1 both life insurance and the Army. Since the age of twenty-one I have been a heavy cigarette smoker, gradually smoking more and more as I grew older ; at twenty-one about twenty ; recently, up to sixty or eighty daily during my four years in Malta (1938 to 1942), though I never smoked a cigarette to the end, rarely more than half.

" The first symptoms I noticed were in 1925 while I was working for the M.R.C.P., when I developed salivation and heartburn. This clear up rapidly by reducing my cigarettes. In 1934 I first noticed cramp in my left calf after walking a hundred yards. I knocked off smoking for a week, then gradually started again, and noticed nothing till 1941, when I had some vertigo, falling to the right when walking. The nearest description is that I felt as if I were drunk and were staggering. This lasted three or four days. I knocked off my cigarettes a bit and the vertigo disappeared, to reappear again in six months for a few days. This time it was accompanied by what was probably a little spasm of my retinal vessels. I noticed steaminess in the right upper and outer quadrant of my field of vision, which lasted for fifteen minutes and then disappeared. It was accompanied by giddiness for a few days. I may point out that after each of these incidents I had myself examined thoroughly by a good physician and an eye man, neither of whom could find anything except tobacco to account for the symptoms. I always cut down cigarettes for a few days, and then went back again to my fifty, sixty or seventy.

On March 1st, 1942, I noticed cramp in my left calf, followed by cramp in my right calf, after walking three miles. Curiously enough, I could walk it off. It stopped at once when I stood still, and recommenced when I walked. This frightened me and I cut down my cigarettes to about forty, but the cramp continued if I walked even a hundred yards. At this time I was having a certain amount of worry and difficulty about my work, and the bombing in Malta was rather trying. The cramp got worse and was continuous, even when I was not walking. It was more of a dull ache, worse at night. Finally, I cut down my cigarettes to twenty-five daily with great difficulty and with no effect. The cramp in my left calf was worse than ever for three months.

" On my return to the United Kingdom in June, 1942, I consulted many distinguished cardiologists and neurologists, who could find no definite cause for the cramp ; cardiovascular system perfect ; dorsalis pedis and posterior tibial arteries pulsating well. No arterial calcification ; blood pressure normal. Everything A 1. I saw Sir Arthur Hurst on July 7th. He said I should stop smoking (I was then smoking twenty-five daily). I stopped at once. The cramp continued for a further two months, until September 7th, when it completely disappeared. I can now walk five miles without noticing anything, though occasionally I get a dull ache in the left calf for a few moments if I think about it. I have now kept off smoking for six months, with the following results :—

(1) My appetite has increased beyond measure ; I eat twice as much as I used to.

(2) I used to have a spastic colon ; now I have nothing approaching it. Stools are normal and formed, where previously they were only partially formed, in small pieces with mucus.

(3) I still want to smoke and have to chew gum and eat sweets to stop the craving, and this after six months.

(4) I have put on a stone in weight."

This admirable account is a clinical lecture in itself and requires no comment from me.

If, on the whole, the results I have outlined permit some satisfaction that the results of smoking are not so detrimental as was at one time feared, that no disease or symptom complex unless it be tobacco amblyopia, can be attributed to this cause, there are certainly no grounds for complacency. The conclusion we have arrived at from clinical and experimental evidence is that tobacco plays an accessory rather than a primary role in the cause of ill-health. Yet a reference to certain statistical studies which have recently appeared, shows the matter in a less favourable light. Shortt and Johnson, in 1938, published in America the results of an enquiry into two thousand insurance policy holders, in an attempt to learn what symptoms, if any, were produced in comparatively healthy individuals by the use of tobacco. A questionnaire was sent to each to obtain information as to their tobacco habits, while, quite independently,

the medical history and physical examination were also obtained. Without going into details the results showed a striking increase in symptoms relating respectively to the respiratory, circulatory and gastro-intestinal systems amongst the smokers, who represented some 60 per cent. of the total. These findings showed a trend in accordance with a preliminary investigation on tobacco and life expectation, published by the late Professor Raymond Pearl in 1938, after a study of nearly seven thousand male lives, unselected except in regard to their tobacco habits. The melancholy conclusion was reached that the smoking of tobacco was statistically associated with an impairment of life duration, and that the amount and degree of the impairment increased as the habitual amount of smoking increased.

As to the question of drug addiction, I do not think the habit of smoking can or should be regarded in this light in all but a few instances—at least not in any sense comparable with the addiction to such drugs as morphine, heroin and cocaine. The true addict is held in bondage by the fear of the severe symptoms which will follow the withdrawal of his drug. This is not so, I think, with tobacco, and I have rarely met with the patient who could not give it up if the need arose. The craving for tobacco, the restlessness and irritability which follow its withdrawal, are rarely of long duration, and many, if not most, habitual smokers who, for reasons of health, have to give up the habit, find it much easier to practise complete abstention than a reduction in quantity. As William James said, when writing of habits : " It is surprising how soon a desire will die of inanition if it never be fed."

I must bring this long and, I fear, very discursive survey to an end, but not without attempting to draw some conclusions from it. Obviously no extreme opinions are justifiable or helpful. Tobacco smoke contains, in appreciable amount, one of the most powerful alkaloids known to science. The smoking of tobacco is increasing with great rapidity. Medical evidence shows that it causes a multitude of minor ailments rather than any major diseases ; that it initiates and aggravates the symptoms of certain diseases, but is not their primary cause. Even so, in the aggregate, it leads to an appreciable amount of ill-health and possibly, in some way not yet fully ascertained, to a shortening of the span of life. The effects seem to accumulate and show themselves especially in cardiovascular digestive and respiratory embarrassments after middle age, when the normal degenerative and involutionary processes set in. These results are sufficiently important to demand a much more vigilant and critical attitude on the part of the medical profession than is discernible to-day. On the other hand, we must concede that tobacco may be beneficial, particularly as a mild sedative, and that for this purpose it is both pleasant and, when used with restraint, even relatively innocuous. In our modern civilisation, with its perpetually recurring wars and rumours of wars, with its unequal distribution of wealth and opportunity, and the attendant fears and anxieties, it may well be that some such sedative is even desirable and has its purpose in the general design. I would remind you of the verse which is said to open the Negro Bible :—" In de beginning de Lord make Adam, and de Lord he very sorry for Adam, so he make Eve ; and de Lord he still more sorry for Adam, so he make tobacco."

Correspondence

STUDENT NURSES' FEES.

To the Editor of the GAZETTE.

SIR,—May I reply to Miss Goodman's letter in your last issue. The fact that a student nurse pays for her training by the skilled work she gives to the hospital is by no means proven. This work is her experience, without which she cannot become a skilled nurse. In every profession or trade, architecture, engineering, dressmaking, the student works for the employing authority ; this is her experience for which she pays.

Why should nursing be considered different from other professions in this respect ? The student's work is done under supervision, the employing authority being responsible for the student's work. How great is the responsibility of the trained staff in a hospital ?

What careful and anxious supervision of the student's work is necessary ? It is hoped that student nurses of the future will not attach less value to their training than women do when training for other professions.

Yours, etc.,

FLORENCE TAYLOR, Sister Tutor.

Guy's Hospital, S.E.1.

NURSES AND RUSHCLIFFE REPORT.

To the Editor of the GAZETTE.

SIR,—In reply to Nurse Tanner's letter in a previous *Gazette*, stating that the proposed increase in pay for nurses is to be regretted by many, there are many who may agree, but many who oppose this statement.

First, let us say the letter suggested that any increase in pay for nurses would imperil the standard of the S.R.N. This is not so, for no money, however big, could ever buy a nurse—for a girl who takes unto herself this profession does not wish to gain materially. She gives the best of her psychological and physical ability to humanity for its good and not for personal gain.

The extra £10 a year that the Rushcliffe Committee proposes to give student nurses will merely meet the present cost of living, and enable those that are not wealthy to become independent, thereby taking a burden off their parents' shoulders. Also the Rushcliffe Report will enable those nurses who wish to continue in their profession to reach a higher standard of living, which is at present impossible unless higher certificates and more specialised training are obtained.

If the Rushcliffe Report comes into force the authorities will have good reason to accept only those who are most suitable. Every nurse has to undergo a course of probation before she can sign her contract; even then a close and experienced eye is kept on her to decide whether or not she be of a suitable disposition and character.

I trust that I voice the opinion of many.

Yours, etc.,

Nurses' Home, Guy's Hospital, S.E.1. JOCELYNE CUMING.

HOSPITAL INFORMATION.

To the Editor of the GAZETTE.

SIR,—Why is it, when hospitals write to doctors about cases, they always adopt such an informative tone ? Even when information is not asked for. There seems to be a standing assumption that doctors who send cases to hospitals are the lowest form of animal life.

I recently had a case of epilepsy in an ex-soldier, which began at the age of thirty-five, after coming home from India. I thought it was probably one of cysticercosis, and X-rayed his leg and arm muscles which were crowded with parasites. Students from a London hospital are evacuated and doing clinical work in a certain hospital near me, and I thought it would be a good case for teaching purposes, so sent him in with a letter to that effect, accompanied by his films and a warning not to attempt treatment with parasiticides which are very liable to cause fatal results. Such cases sometimes clear up in four or five years with death and calcification of the parasites and can usually be controlled by luminal.

I received a letter saying, " With reference to Mr. X—— the cause of this man's epileptic fits is clearly revealed by his X-ray films. It is one of cysticercosis and no treatment is advised other than luminal gr. $\frac{1}{2}$ tds. for relief of the fits. It is not advisable to treat these cases with intravenous tartar emetic "—and he was discharged.

A case of acute appendicitis was sent in (one of innumerable instances) with the correct diagnosis, for operation. I usually get one of a stereotyped form of letter, saying : " Dear Sir,—Mr. So-and-so, whom you sent into this hospital on Monday last,

proved to be a case of acute appendicitis and he was operated upon the following day." Well, that's what *I* said !

Another case had complained for months of paroxysmal pain in the right hypochondrium about two hours after food. I gave her a barium meal and X-rayed her and found a greatly deformed duodenal cap, so sent her in as a D.U. I was told that "Mrs. F—— was seen by Dr. Brown-Jones to-day. He considers her to be a case of gall-stones "—(which I had already excluded). I replied that whatever else it might be it was neither gall-stones nor cholecystitis, that a barium meal showed definite evidence of D.U., a fractional analysis showed marked hyperacidity, and the last specimens withdrawn contained blood."

After this I was informed : "Dear Sir,—Mrs. F——, who was sent in by you as a case of doubtful abdominal pain, is a case of duodenal ulcer. She is being retained for treatment." I sent her in as a definite case of D.U. and *not* as one of "doubtful abdominal pain " !

Why are such letters written and who writes them ? After all, mere worms though we be (I remember hearing a student say that a case had been sent in by "some bloody G.P.") we have our feelings !

Was it not Cowper, in "The Task," who said :—

"I would not enter on my list of friends,
Though graced with manners and fine sense yet lacking sensibility,
The man who inadvertently sets foot upon the worm
That crawls at even in the public path " ?

Will you please remember that, gentlemen, whether you are (A) or (B)s ? I think you must be (B)s !

I am, etc.,

"CARFAX."

P.S.—It was not Guy's Hospital !

Sector News

Guy's Letter

GUY'S played its part in the London "Wings for Victory " effort, and a dance organised by Sister Woodfield and the theatre staff, contributed £18. Mr. Eckhoff's bottle of whisky, which was raffled, played no small part in making up this total, and was a topic of conversation for days beforehand. There was also a collecting box in Nuffield House, which gathered the sum of £7 from all and sundry.

While both the house physicians were said to be contemplating matrimony, one has already taken the plunge, and we offer our heartiest congratulations to Laws on his recent marriage.

It has always been a source of annoyance to those who work in Out-patients' to be presented by a patient with his doctor's visiting-card on which is scrawled in writing of variable legibility words such as "Please Examine " or some other terse but unenlightening sentence. Sometimes, of course, there it more information supplied, but often it is of the scantiest kind and, on enquiry of the patient, one may find that he has been attending his doctor for some time. In other cases it is apparent that the patient has received an inadequate examination or no examination at all before being sent on to the Hospital.

This state of affairs is highly unsatisfactory from the point of view of both hospital and patient in obtaining the best possible treatment. It may be argued that in these days when some general practitioners are doing the work of one or two of their colleagues in addition to their own, they have not the time to write out a fuller history or make a more detailed examination of a patient who will obviously need hospital treatment. However, as the majority of practitioners seem able to provide a reasonable letter with their patients, there is no reason why the minority who don't should continue this practice which is both bad medicine and bad manners. R. I. M.

Acrylic Resins

By J. W. MANSIE, M.R.C.S., L.R.C.P., L.D.S., R.C.S.

ACRYLIC resin has been used in industry from about 1930. One of its forms is "Perspex," which is used in the manufacture of aircraft windshields and windows. The resin in which we are interested is methyl methacrylate. In its monomeric form it is a colourless liquid with the typical ester smell. It is generally obtained from acetone. Under the influence of various stimuli, heat, ultra-violet light or contact with its polymer, and, in the presence of oxygen, the liquid monomer polymerises and becomes a solid, contracting as it does so. Polymerisation can be induced in such a way that very fine granules are formed. These granules of the polymer saturated with liquid monomer form a putty-like mass which can be injected into moulds or pressed between dies and then polymerised by heat. The polymer is also thermo-plastic, beginning to soften about 80 deg. C., and at 160 deg. C. can be injected into moulds. In industry the polymer is used and injected in the softened state under high pressures which are in the range of 10,000—30,000 lb. per square inch.

One of the properties of methyl methacrylate is that it is well tolerated by the body tissues. This enables it to be used in the treatment of fractured bones in the place of metal plates. Its translucency is an advantage in the making of contact lenses and artificial eyes. In the treatment of osteo-arthritis of the hip joint, methacrylate cups have been fitted which replaces the diseased articular surface of the head of the femur*. From these few examples it can be seen that there is a wide surgical field for the development of this material.

Considerable work has been done in the use of methyl methacrylate in dentistry. It can be used as a denture base and, suitably coloured, makes very realistic artificial teeth, which in appearance surpass those made of porcelain. In addition, owing to its peculiar qualities and the relative ease of technique, it can be used in situations in which porcelain is impracticable.

Before considering the use of methyl methacrylate as a denture base it is well to compare its chief properties with those of vulcanite. These figures will be affected by the method of moulding :—

		Vulcanite.	*Methyl Methacrylate.*
Hardness	kg.-mm^2	13–19	16–22
Tensile strength	kg./cm^2	490–555	575
Impact strength	cm.-kg./cm^2	11–43	10–12
Transverse strength	gr.	4000–8000	5500–7500†

In some of the commercial products a plasticiser is added, usually in the form of a phthalate and in the proportion of about 0.5 per cent. The effect of this addition is to decrease the hardness and increase the elasticity and tensile strength. To acids, alkalies and most chemicals methyl methacrylate is inert, but it is attacked or dissolved by the aromatic hydrocarbons, ketones, esters and phenols. Useful solvents are chloroform, ether and acetone. Water absorption is in the region of 0.5 per cent., but although water absorption is usually taken as the index of the fouling of a material in the mouth, methyl methacrylate does not become foul. Repairs are easily effected because the additional material fuses completely with the old. It is unnecessary, therefore, to make any retaining keys or dovetails.

The consistency of the material is similar to that of horn. It can be cut with a sharp knife, ground with a dry stone or burr, and easily polished.

DENTURE BASE TECHNIQUE.

Until the stage of flasking the denture the technique is similar to that used for vulcanite. In flasking, however, it must be remembered that because steam pressure is not used the plaster will not be soft after the case is processed, but will be as hard as before processing. A flask must be used from which the plaster may be removed so that the case may be cut out easily. It is not necessary to tin-foil the case, which is invested in the usual manner. The wax is washed out and the plaster dried. The

plaster surfaces are then coated with a solution of celluloid in acetone, or one of water-glass in water, or with one of the proprietary solutions. While this is being done the resin is mixed. Sufficient polymer (powder) is poured into a small vessel and saturated with the liquid. Excessive powder will prevent the formation of an easily worked mass and too much liquid may result in excessive contraction. The surface of the mixture should appear just wet. The vessel is covered to keep out dust and left undisturbed for ten or fifteen minutes. At the end of this time the surface of the mass will appear matt and its consistency will be that of moist dough and sticky. If, on stirring, fine threads appear, it will be ready for thorough mixing. The mass is worked until it is of the consistency of thick dough and can be handled without its sticking to the fingers. It is now pressed into the half of the flask containing the teeth, covered with a sheet of moist celophane and the other half of the flask is placed in position and pressed down, but not quite home. The flask is opened and any excess cut away. It is a good plan to close the flask again and to wait until the resin is fairly stiff before closing it right down. The method of holding the halves of the flask together is very important. The spring loaded flask, such as the " Luxene " flask, is the best method and various devices can be used to arrive at the same end—which is to keep up a strong pressure during processing. The reason for this is that during polymerisation the material contracts while its density increases, and the pressure applied at this time will ensure the complete closing of the flask and also prevent porosity. The flask and spring-loaded clamp are now put into a saucepan of cold water. Heat is applied to bring the temperature of the water up to 60 deg. C. in the space of half-an-hour. The temperature is kept at 60 deg. C. for another half-hour and then brought to boiling point and kept there for not less than half-an-hour. The reason for the slow heating in the early stages of polymerisation is that further heat is produced during the process. If polymerisation is hurried the rise in temperature may be accompanied by the formation of bubbles in the material which will produce porosity. That this is due to the internal production of heat can be shown by the fact that the porosity occurs in the middle of the thickest parts of the material. After the flask has been allowed to cool slowly, the case is removed. Great care must be exercised in order to avoid cracking teeth; a fairly high proportion of cracked teeth occur through careless deflasking. The denture is then finished in the usual way.

In making teeth for full or partial cases, one of several methods may be used. A model of an individual tooth can be carved in wax, invested and packed in one shade or a combination of shades to suit the particular requirement. A tooth from a mould guide may be used to make the mould, or in the case of an immediate denture a wax model of the tooth to be replaced can be made from a " Zelex " impression of it. In the case of full dentures porcelain teeth may be tried in the mouth in the usual way. These can then be tin-foiled and invested, the porcelain teeth removed and resin packed into the mould so formed. The arches made in this way are then mounted in wax, tried in the mouth again, and finished with resin bases. One of the advantages of this method of making dentures is that the denture is uniform and therefore stronger. In addition, the possibility of teeth-clacking is eliminated. It is light and the grinding in of the bite is easily and quickly accomplished. Wear does not appear to be excessive. For making teeth the plasticiser is eliminated and so the material is harder than the denture base. In partial cases with a close bite the problem of attaching teeth to the plate is simplified.

Jacket crowns and post crowns may be made very easily. The amalgam model of the jacket crown preparation is tin-foiled, using the same method as is used with platinum foil. The tooth is then built up with pink wax on the foil and then removed from the model, invested, packed and processed. In making a post crown, a post is fitted to the root and the tooth carved in wax on the stump in the mouth. This is then removed, invested and packed. Adaptation is very accurate.

Inlays may be made from wax patterns, using a burr shank for a sprue former. The burr is mounted on some form of plunger and the wax covered with osteo cement. The apparatus is invested in such a way that the plunger forms a piston attached to the upper half of the flask which forces the resin dough into the mould. It can be seen that facings and pontics for bridges can be made on a gold skeleton very much more simply than by using porcelain.

It is admitted that this material is still in the experimental stage, but it can be said that it is now in the clinical stage of trial and that although great modifications both in the material and the manner in which it is handled will take place, the principle of using a plastic for the replacement of teeth will remain.

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Hospital Information, etc.

Pass List

ROYAL COLLEGE OF SURGEONS.

L.D.S.

FINAL EXAMINATION.

February, 1943.

PART I.—*Surgery.*

A. W. Bevis	A. J. Goodwright
T. T. Billington	P. C. Grummitt
L. R. E. Bradford	W. R. Hall
N. P. Bronsden	P. D. Harvey
J. C. Cox	H. Mistlin
P. C. J. Crisp	J. P. Pearce
A. J. R. Davies-Evans	G. N. Pleasant
J. Elder	F. B. Sartory
E. A. Glover	P. J. Wardill

PART II.—*Dental Surgery.*

D. J. Anderson	G. G. Jackson
B. M. Barker	E. S. Jerichower
L. R. S. Bradford	P. H. S. Lahaise
G. C. Christian	H. C. Martin
T. C. Collins	D. Middleton
G. C. Fuller	J. P. Pearce
A. A. Halamandres	J. A. W. Purnell
R. J. Hunter	D. A. Reaney

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION

March, 1943.

Surgery.—W. H. Lillywhite.

Medicine, Pathology and Forensic Medicine.—*J. M. Hanson.

Midwifery.—A. G. Wolstenholme.

* Has completed the examination.

Notice

To end on a lighter note, we here reproduce as far as possible accurately, a letter received by a Guy's man in general practice from one of his patients. Suggestions as to the right course of treatment for this patient should be sent to the *Gazette* office. A prize of a sixpenny savings stamp will be paid to the sender of the best letter, as a reward for ingenuity and to help cover the cost of the inspiration needed :—

"To Dr. chest is still phlegm cough now again thick up out of mouth rise head giddy stomack food repeats water gets irritable after but it stood not like was not to hold it wind restles sleep dont seem so like it was round ribs but it gets in sides acke at times the flue have made me so weak after fluid is gets so soreas it passes hot cant rest for while pile seem bit cooler chest is so sore from stuff coming up bowels seem so sore when walking about.—MRS. TOMPKINS."

Awards

M.C.

Capt. O. I. Green, R.A.M.C., has been awarded the Military Cross in recognition of gallant and distinguished services in the Middle East.

Prisoners of War

Capt. Harold Bloom, R.A.M.C., Prisoner of War in Italy.

Jacob Cunard, Capt. South African Forces (278464), Camp 29 (P.M. 3200), Italy.

Change of Address

G. F. Gibberd, Lieut.-Col., R.A.M.C., 94th General Hospital, British North African Force.

Births

BARNARD.—On March 5th, 1943, at Guy's Hospital, to Gwenllian (née Thomas), wife of G. E. Barnard—a son (David).

Marriages

HARVEY — PRIDDEY.—On March 6th, 1943, at Ruislip, Edward Harvey to Sylvia Priddey.

LAWS—SQUIRE.—On March 13th, 1943, at Caversham, Reading, J. O. Laws to Sheila Squire.

WINN—CLOSE.—On March 8th, 1943, at the Royal Garrison Church, Woolwich, Captain Henry W. J. Winn, R.A., of Balcombe Lodge, Haywards Heath, to Gwendoline Ann Close, of Westbury-on-Trym.

Deaths

PINCHING. — On February 23rd, 1943, Charles James, O.B.E., M.B., B.Ch., of Gravesend, aged sixty-eight years.

RYDER.—On March 9th, 1943, Maude Le Clercq, wife of J. F. Ryder, L.D.S., R.C.S., 46, Richmond Hill, Surrey.

EDS. { P.F.E.B. J.O.L.

GUY'S HOSPITAL GAZETTE

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PASSIM

NO one who has seen the notice in the Medical School about a famous prize essay can have failed to be impressed by the subject, "The Use and Abuse of Sulphonamides." It is a measure of the prominence these compounds have obtained that, in the nine years since the first was introduced, experience and experiment should have accumulated sufficiently to be thought worthy of the attention recorded above. The prominence given to the abuse of the drugs is, however, less flattering to the medical profession; it suggests that experiment has outrun experience, and how often have we been told that science misused is a potent weapon of disaster. No, we have no time to waste these days in the matter of chemotherapy, and the medical profession must realise that if it is to keep up with the advances of science and to check too rapid and unwise advances in this sphere, it can do it only if it is itself well up in the van. In other words, we can no longer wait till the slowly accumulated experience of years has worked out the advantages and disadvantages for each one of us separately, as was the case, perhaps, in days gone by. The pace is now forced by the scientist who produces more and more powerful drugs each day, and only by close co-operation, and a standardisation of technique quite foreign to the older style of medicine can we adequately control the use, and the abuse, of the new drugs.

The above remarks are emphasised even more by events recorded in one of our distinguished contemporaries this week, where, in an article of two pages or so, is recorded the effect of pantoyltaurine in inhibiting the growth of streptococci in the rat. You may say what significance has this, as the article does not pretend that this substance has been adequately tried out in man, but it is the method that is significant. For the first time an efficient chemotherapeutic agent (for the rat at least) has been found by following up a theoretical possibility, instead of the development of an accidental discovery. The workers took as the basis the requirements of some bacteria of a supply of pantothenic acid for their growth, and then they deliberately schemed to deprive the organism of this necessary factor by the method known to occur in the action of the sulphonamides—namely, the saturation of the enzyme system concerned, with a related compound, which is, however, inactive. And, which is more important than the method, they succeeded. So that with new discoveries about the growth processes of bacteria, which are steadily being made, we may expect new advances in chemotherapy to correspond.

There is, however, one field in which so far chemotherapy has met no success, that of tuberculosis, and for that reason it is important to avoid a reduction of our present methods of defence and offence in this disease. It is, therefore, with considerable misgiving that we must have read the announcement of the imminent closing of a home and re-education centre for tuberculous boys. The reason is the shortage of staff and all of us who are in hospitals, or in close contact with them, know that it is a very real difficulty. This must not stop us trying to overcome the difficulty with every means at our disposal, and it is hoped that the recent registration of all trained nurses will help to make available a further supply of this one requisite at least. Whether the shortage of domestic staff can be overcome as easily remains to be seen, but it is essential both to the future health of the nation and to the present war effort, that no spread of tuberculosis should be allowed to occur.

MOST Guy's men will probably have noticed in the papers the description of the heroic deeds of Surgeon-Lieutenant Evans, R.N.V.R., of the Canadian corvette *Weyburn*. He directed the treatment of the survivors for twelve hours, in spite of having himself sustained fractures of both legs while in the water after the sinking of his ship. We understand that he is now in hospital in Scotland, and we offer him best wishes for a quick recovery, knowing that all Guy's men will join us in this and feel proud that a member of their Hospital has thus distinguished himself.

The Care and Treatment of Amputations*

By A. W. J. CRAFT, Esq., M.R.C.S., L.R.C.P.

THE preparation of an amputated stump for an artificial limb has been described in a previous article.† The care of an amputated stump whilst a limb is being worn, and the treatment of a lesion or breakdown which may occur from various causes, is not fully realised by many patients nor by many concerned with treatment of such conditions.

An amputee, apart from having to accustom himself to the use of the artificial limb and acquire the necessary skill to control it, should realise there are many factors to be considered for maintaining the stump in a healthy state. New strains and stresses are imposed upon the musculatures and in some complicated cases with multiple scars there may be some unavoidable pressure exerted upon the scar with serious consequences, if the scar tissue is not correctly treated. The stump sock is in contact with the scar and the friction thus caused can and does cause irritation.

Whilst a normal person is walking or standing the weight of the body is taken upon the foot, but with an amputated leg this is impossible and it must be taken elsewhere. Theoretically it should be taken upon the only other site designed by Nature to take weight—the ischial tuberosity. In amputations above the knee this is universally adopted, but with below-knee stumps it is distributed over other areas, a great deal being taken by the head of the tibia, which frequently breaks down from a bursitis and other lesions. In arm amputations weight-bearing does not have to be considered, but other conditions need attention.

The excellent prostheses now made for upper and lower limbs certainly minimise the strains imposed upon musculature, but well-fitting limbs cannot overcome neglect of the stump. On the other hand, unless a limb is correctly designed and properly fitted it will cause discomfort and injury.

Some lesions are common to all stumps, including arms, whilst others are mainly though not always confined to one type of stump as, for example, bursitis on the head of the tibia. Under present war-time conditions an artificial limb may have to be worn for very long periods and small but progressive conditions are often overlooked until they become too painful for the limb to be worn.

In new amputation cases the stump should always be bandaged when the limb is not worn, especially at night. Failure to do this allows the stump to swell during the night with a consequence that the socket feels tight when worn during the first few hours of the day, and as the stump shrinks it becomes loose. The skin surfaces thus exposed to friction will become inflamed.

Perhaps the most important care of stumps is that of personal hygiene, and is most often neglected.

All amputation stumps should be carefully washed with a good quality soap every day, if possible a soda-free soap being used which does not require to be "dried off." The ordinary skin may be washed normally, but the scar tissue itself should be treated very gently. Using ordinary soap the lather should be washed off and the towel applied very lightly on the scar without any rubbing to produce friction. Surgical spirit should be lightly applied to remove all remaining moisture and finally dusted with a good quality talc powder.

It cannot be too strongly emphasised that stump socks should be washed regularly. A clean sock should be worn each day next to the skin to avoid any infection of the skin from the excretions which are absorbed by the sock.

Stump socks will shrink unless washed correctly and may not only cause constriction in the stump, but become too short, thus allowing the skin to be abraided by contact with the top of the metal socket or leather corset. Similarly the crepe bandages used to reduce œdema and prevent the stump swelling at night should be washed regularly.

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* This article is based upon work as a Limb Surgeon of the Ministry of Pensions at their chief limb fitting centre at Roehampton, and as is well known the Ministry of Pensions has had a very extensive experience of limb fitting and examination with the appropriate treatment for the amputees.

† Guy's Hospital Gazette, Vol. LVI. No. 1401.

Lacerated wounds on stumps vary from the simple graze or abrasion to the severe forms occurring from street and machinery accidents. They vary in shape and depth, the surrounding skin being torn, crushed, and having areas of damaged tissue around the wound. There may be foreign matter embedded in the tissue. Owing to the destruction of the nerves in the area there may be little actual pain. Blood-vessels being torn contract to some extent, minimising the loss of blood.

Incised and punctured wounds may be produced by a sharp edge. Careful examination should be made to ensure no deep strictures, such as important nerves or tendons have been injured, otherwise serious deformities and disabilities may result.

In treating wounds generally the first consideration in severe cases is the arrest of hæmorrhage. The wound should be irrigated with a warm sterile or antiseptic fluid, care being taken not to use strong antiseptics which may delay healing. Exploration of extensive and serious wounds may be necessary for surgical reasons. Sterile or aseptic dressings are applied and held in place by firm bandaging. Rest is essential until the wound is fully healed and the scar consolidated before the artificial limb may be worn on any stump which has had a wound.

A contusion may be caused by a heavy blow on any part of a stump either by a fall or weight falling upon it. There is an injury to the soft tissues and the skin is not broken. There is an extravasation of blood in the torn or damaged tissues which by the changes in the pigments of the blood during absorption shows a bruise with a swelling under the skin often accompanied by pain. If the extravasation of blood occurs under a deep layer, such as the fascia lata of the thigh, it may be some days before the bruising shows through the skin, and then it may show itself some distance from the site of the injury, owing to the blood having tracked further down the tissue.

If a stump is bruised and causes pain when the artificial limb is worn the limb should be left off. The stump should be rested and cold compresses applied under a firm bandage in an effort to limit the spread of the effusion. If the bruising is extensive a hot bath or immersion of the stump in hot water will be useful in relieving pain, together with normal sedatives for the patient. Later the absorption of the effusion may be assisted by gradually increasing movements of the stump to exercise the musculature.

If a larger vessel is damaged there may be a localised effusion of blood forming a hæmatoma. This may be seen as a fluctuating mass in the bruised area, with usually hardened edges due to the coagulation of the blood in contact with the damaged tissues. Such a collection of blood may remain fluid for days and slowly be absorbed. It may make a favourable medium for the culture of bacteria, if allowed to enter the hæmatoma from any lesion. A hæmatoma of medium size may be left to become absorbed. If it is large it may be necessary to draw off the blood or even incise and turn out the clot. It is important to observe all aseptic precautions to avoid infection and suppuration in any hæmatoma. An infected hæmatoma may cause much greater post-operative nerve pain than a tissue or bone sepsis, the latter being limited by the periosteum.

Infected and suppurating hæmatoma have all the signs of an abscess and are treated as such.

An abscess is a localised suppuration in the deeper tissues of any stump. The infection may be from a small lesion on the skin, or from the blood or lymph stream such as frequently seen in the lymph nodes in the perineum on and above knee-stump. The artificial limb must be left off and the stump rested until the abscess is evacuated and the scar consolidated.

Many methods are in use for treatment. In the early stage of infection a hot moist fomentation frequently renewed upon the area increases the flow of blood to the part. The abscess usually bursts and the pus is exuded, when the site can be treated as an ordinary wound. It may be necessary to incise an abscess. It is most important to consider where the incision is made. Scars should not be large and not on the area of the stump which has to take any direct weight bearing or pressure. A little consideration regarding the position of scars especially in above-knee stumps will be of inestimable value to the patient and obviate later breakdown of the scar when the limb is worn again.

The skin and subcutaneous tissues suffer from chilblains caused by poor blood circulation in many patients. The affected area appears tense and full, the skin being shiny and red, often dark in colour with an intense itching or burning. The condition chiefly affects the long amputation stumps and very few cases have been seen on the ideal length of stump. In many cases the condition is generalised, not only the stump itself has chilblains, but the extremities of all the other limbs.

If the patient has suffered from this condition over a number of years there appears to be no satisfactory cure, although some relief is obtained by short exposure to ultra violet rays and in extreme cases to X-rays. Various attempts to increase calcium metabolism have given relief. A mild anæsthetic ointment has been applied in many cases with good results.

The distal end of a stump may become painful before a limb is worn or during the early stages of limb-wearing. A sequestrum from the amputated bone may cause this with a local, sometimes widespread, pain and an inflamed area of skin over the stump-end. In such cases an X-ray will show whether a sequestrum, bone spur or a foreign body is present. Small sequestra usually work to the surface and become exuded. Larger forms may have to be removed surgically.

Bone spurs tend to form along the muscular insertion or on the ends of all bones. With smaller bones such as the radius, ulna and fibula they may grow towards the adjoining bone or even distally on the bone end. If they cause pain they may need removal of part, if not all, of the spur. Unfortunately, in some cases, they tend to recur.

Sinuses sometimes remain and continue to discharge in amputation stumps. They may result from poor drainage following an operation owing to an inadequate incision, or not placed at the most dependent point of the area to be incised and drained. Foreign bodies, necrotic material, insufficient rest of the stump after operation as well as tuberculous and syphilitic infection also cause sinuses.

An X-ray of the sinus after injection with lipiodol or other similar liquid will show its course and whether the discharge is emanating from an area around a foreign body. If a foreign body is detected it may have to be removed to assist final healing. T.B. and syphilitic infections will require suitable treatment for the underlying course. Septic lesions in many cases respond to sulphonilamide powder being lightly applied. Some patients cannot tolerate this external application and the skin becomes more inflamed. Similarly, the application of too great an amount or for too long periods also creates a sensitivity to sulphonamides. In such cases the treatment should be stopped and calamine lotion or similar soothing medicament applied to assist in general healing.

In the past operating surgeons have not co-operated with those responsible for the fitting of artificial limbs to the same extent as at present. The modern artificial prosthesis is the result of close study by limb-makers and surgeons who periodically see patients wearing limbs. The ideal position of scars for every amputation is definitely proved by the results obtained and recorded during the past twenty years. The breakdown of scar tissue in leg amputations does not occur with the larger anterior flap method. The scar is formed at the lower posterior surface with normal thickness skin over the end of the bone. It does not have any pressure exerted upon it with above or below-knee amputations. If the equal flap method is used the scar forms over the end of the femur or tibia, and adhesions occur between the scar tissue and bone. This does not prove satisfactory owing to the vertical movement of the stump in the socket, or piston action of the stump, constantly pulling the thin tissue over the bone and weakening it.

In arm amputations the scar is best situated at the end of the stump. There is no piston action in the use of the artificial arm and the scar tissue which may adhere to the bone is not injured.

Cases are seen of scars situated where the upper part of an above-knee-stump rests on the brim of the socket. They not only cause pain to the patient, but are constantly injured by friction and repeatedly breakdown. The scar is usually from an incision to relieve a furuncle, and if it was made lower in the stump it would give greater comfort to the patient when he resumes limb-wearing and not require further attention.

Indurated scars are also a source of breakdown and should be avoided. It is difficult to attend to the hygiene of infolded tissue which is generally a source of

intertrigo. Eventually an operation is necessary to provide an even surface to the end of the stump. Unfortunately the manual worker who sweats a great deal is the patient who suffers most from scar irritation because he is less able to change the stump sock daily and wash his stump. Surgical spirit has no advantage over the use of soap and a good powder in treating irritated skin lesions and scar tissue.

Scar tissue may ulcerate from pressure or from the effects of a socket fitting too closely near the stump end and causing a tension of the tissue. The limb should not be worn and the ulcer allowed to heal completely. When limb-wearing is resumed strips of elastophast may be placed over gauze on the scar to decrease this tension if the limb is not refitted. If the ulcer does not heal or recurs it should be excised when there is sufficient skin, otherwise tension is increased on the new scar and it will probably ulcerate again. Even a short re-amputation may be advisable if the scar is terminal and adherent.

Circulatory defects also occur in stumps which are longer than the present recognised ideal lengths. The stump-end becomes cyanosed, cold, painful and may eventually ulcerate. Re-amputation in these cases at the site of election is unavoidable. The cyanosis of long below-knee stumps has been accentuated in the past by supporting the weight of the body on the head of the tibia. Fitting an ischial bearing corset in below-knee limbs affords some relief, but re-amputation may have to be performed at a later date.

Cases are occasionally seen with corns on the end of a very long stump and around the head of the tibia, owing to continued friction and pressure from wrongly fitting limbs. These hard corns are treated by refitting the artificial limb to remove the source of irritation, whilst the area of the corn is painted with a mixture made of 60 grains of salicylic acid to an ounce of collodion, twice daily. This destroys the epidermis and loosens the central plug, which eventually separates. Patients with impaired circulation should not cut corns; they can be infected, which may lead to ulceration.

Bursæ are situated normally in many places on the body around joints and form a protection against pressure and friction, but if a bursa becomes injured or subjected to undue friction, it becomes distended. The most common site of enlarged bursæ is around the knee-joint, caused by friction against the socket. They are rarely seen near the ischial tuberosity or the olecranon in arm-stumps. Repeated slight friction between the skin and socket causes an inflammation with a resultant bursitis. The limb should not be worn.

Infection of bursæ is usually of staphylococcal origin from an external source, although it may occur *via* the lymphatics from neighbouring septic lesions. The pus, at first confined to the sac, may affect surrounding tissues setting up an abscess, or cellulitis. Treatment consists of incision and drainage, although the excision of the sac may be necessary if the wound does not heal completely.

Large adventitious bursæ forming round the knee-joint may not be painful, but do interfere with the wearing of the prosthesis. They should be surgically removed. Fibroid bursæ are occasionally seen in patients who have been wearing a limb for a number of years. Unless they cause discomfort or become infected they should be left alone, due clearance being given in the socket of the limb.

The exercise of the leg musculature in walking, and to some extent the use of the prosthesis in arm amputations, assists in the restoration of the lymphatic system which finally reduces the œdema. The shrinkage of an above-knee-stump causes the ischial tuberosity to fit further inside the brim of the socket with the result that the pubic bones rest on the socket in the adductor region. The slight up and down movement of the stump in the socket, termed piston action, whilst walking causes friction in this area and often leads to inflammation of the skin. As a temporary measure an extra sock is worn to allow for this shrinkage, and raises the ischial tuberosity. Shrinkage may continue, requiring additional socks, when the socket must be lined or refitted to the new shape of the stump.

The inflammation caused usually leads to a staphyloccal infection of the hair follicles with a subsequent swelling of the tissues and glands. If this is neglected the subcutaneous tissues will suppurate and the single lesion may spread, causing a furunculosis.

The inflamed area may be treated in the initial stage with 1–2 per cent. gentian violet aqueous solution. If the inflammation does not subside it indicates the follicles are infected and the artificial limb should not be worn.

Hot fomentations are repeatedly applied or an application of kaolin, renewed as necessary until the central core discharges. The site will then heal normally.

If the infection is widespread or resistent to the above treatment it may be necessary to surgically remove the infected tissues. It is most important that special attention should be given to the position and direction of the incisions in above-knee stumps. A wrongly placed scar has in many cases prevented the amputee from wearing his limb for long periods and caused repeated breakdown. The scar should be placed so that no direct full pressure is exerted upon it from the upper part of the socket when the limb is worn again. A small incision vertically below the inguinal area gives a more satisfactory result than one in a transverse direction. It will obviate the pulling apart of the healed edges of thin scar tissue and limb-wearing may be resumed earlier, thus reducing loss of time from work.

If the artificial limb fits satisfactorily and furuncles still recur the whole condition of the patient's health should be investigated and treated. At the present time under war conditions there are more cases of this complaint, partly owing to the long hours during which the limbs are worn and to the difficulty in having limbs adjusted. Neglect of the early symptoms by the patient is another cause. Furunculosis occurs in the follicles of lanugo hair seen on the upper part of the above-knee stump and occasionally around the knee-joint. It is quite distinct from sycosis, a staphylcoccal infection of the follicles of normally well-developed hair on other parts of the body.

All amputees suffer some discomfort in the stump following the actual operation; in some cases it may quite disappear a few weeks after the operation, whilst in others it may last for a considerable period. Some stumps are stated to be painful, whilst others are described as being tender. When a sensory nerve ending is irritated pain is felt; if there is abnormal sensitivity to touch it is more correct to describe the effect as tenderness, which occurs when the area has any pressure exerted upon it. Some stumps are tender over a wide area with no apparent underlying cause. Various treatments have been made, but it appears it is more satisfactory to rest the stump and not proceed with limb-fitting until all tenderness has ceased. If the patient can be occupied to distract his attention from the stump condition it greatly assists his recovery.

A stump may be tender in one localised area, which, if the absence of foreign bodies is confirmed, usually arises from a neuroma. All cut and lacerated nerves tend to grow again, with the result that a bulbous ending is formed. Palpation of the area or the wearing of a limb may cause an acute local tenderness only whilst the pressure is applied. If a limb is worn the socket can and should be eased to prevent all pressure on the tender site. If the neuroma still causes discomfort a course of anodic treatment gives some relief, with sedatives such as bromides and phenobarbitone, always keeping the stump warm during the day, and with a hot-water bottle at night. The arm has a larger number of sensory nerve endings and consequently more neuromata form. If these become painful the fitting of a limb is very difficult; in fact, may not be fitted for a considerable time. The pain appears to become fixed centrally and persists for long periods. It is definitely established from results obtained over a number of years that the excision of neuromata, injection of nerve trunks and massage do not cure or lessen the discomfort caused by neuromata, but rather aggravate the condition.

In contrast to a local or widespread tenderness in a stump there may be a continual or periodic pain which is present without palpation of the stump or the wearing of a limb. This may be caused in any part of the stump by an inflammatory reaction to sepsis in the tissues, bone or a nerve, and careful examination should be made of the stump itself and its previous surgical history.

An inflammation, or recurrence of inflammation, may respond to fomentations and rest, or an abscess may form which requires surgical treatment. If sepsis of the bone is suspected an X-ray should be taken. A bone abscess may require an opening of the soft tissues down to the bone, the bone being gouged away to curette out the pus and the cavity swabbed out with peroxide or pure carbolic. Some surgeons close the wound which may heal by first intention, whilst others insert a drainage. If a sinus

persists, which may occur in T.B. and syphilitic cases, the fundamental cause should be treated and possibly further surgery will be required to the bone.

Pain may be caused in a stump from a neuritis which may be felt only on palpation and pressure or there may be a constant sensation of pain present. The severity of the pain appears to vary directly with the trauma to which a nerve has been subjected prior to operation and also to the degree of sepsis in the nerves and other tissues which necessitated the amputation. All this data should be available to those dealing with amputees. Any case which has had a neuritis could well be delayed in the fitting of a limb to avoid irritating the recovering nerve, apart from possibly subjecting it to further injury.

Some patients have a roll of flesh forming at the top of a leather corset on a below-knee prosthesis, and a few develop a roll at the top of the limb worn for an above-knee amputation. No treatment or surgery is necessary, but the artificial limb requires refitting if the condition is not too far advanced. In some cases a profuse swelling of the tissues in and above the popliteal fossa occurs with below-knee limbs. This, again, is a matter which can be treated by refitting the limb, adding a polycentric knee-joint, which has been designed by, and is supplied by, the contractors to the Ministry of Pensions. This gives greater ease and mobility to the knee itself when the prosthesis is worn, reducing friction and assisting in the prevention of bursitis.

There are no other special infections of the skin peculiar to amputation needing any attention other than that appropriate for the condition.

May it be suggested that when an amputee is referred to a limb-fitting centre, a complete pre- and post-operative surgical history would be appreciated for record purposes and reference when the amputee may attend at a later date for any attention to the stump or limb.

In conclusion, the writer would like to express his sincere thanks to the Director-General, and Medical Officers, of the Ministry of Pensions for their permission to publish these notes.

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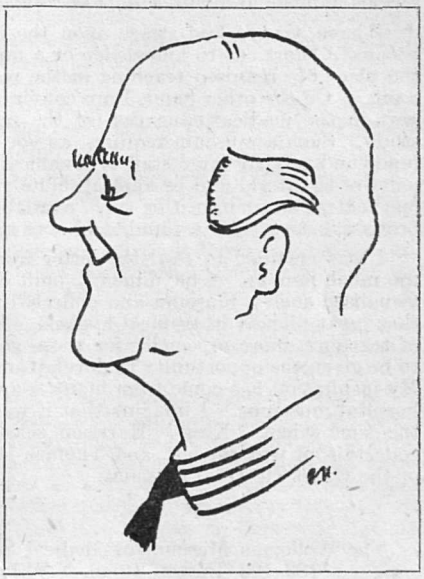

Correspondence

NURSES AND RUSHCLIFFE REPORT.

To the Editor of the GAZETTE.

SIR,—I should like to second the proposal made in a previous issue, to the effect that we welcome the Rushcliffe Report. It is at least a beginning to the improvement of the working and recreationary conditions of the student nurse.

It is essential that these conditions are standardised and improved if the nursing profession is to uphold its traditions during this war and the post-war era.

But conditions do not improve themselves; we are responsible. We must strive for our own Utopia if we wish to attain it. What is this Utopia? As I see it the demands are not excessive—merely the right to live in an ordinary and natural fashion, everyone having an equal chance of success in the nursing profession; the abolition of petty restrictions on personal liberty; adequate time for study and recreation; and, finally, a rate of pay ensuring individual independence and the rights of all student nurses as of every other working girl.

Yours, etc.,

J. C. HAWKES.

Nurses' Home, Guy's Hospital, S.E.1.

PICTURES OF DISEASES.

To the Editor of the GAZETTE.

SIR,—I have read your correspondence and leading article on the above subject with great interest. I am very glad that in the latter you underlined the limitations of this method of teaching. Your title is somewhat misleading, for a museum of the type to which Mr. Sharp refers must include a complete range of zoological and pathological specimens (microscopic and macroscopic), pharmacological exhibits, models, charts, drawings, radiographs and photographs.

For nearly twenty-five years I have been responsible for such a museum. I have developed it on lines which seemed to me to be sound and have studied its value as a teaching instrument. In 1929 I wrote a book, "The Medical Museum," which dealt fully with the subject. Since that time the Wellcome Museum of Medical Science has made rapid progress and been freely used both by students and teachers. Unfortunately, owing to enemy action, it is now closed, but the collection escaped serious damage and will, I hope, be quickly reinstalled at the end of the War.

I have always laid stress upon the importance of not allowing such a system to become a short cut to knowledge or a method of spoon-feeding. It must never usurp the place of organised teaching in the wards, out-patient department or post-mortem room. On the other hand, I am convinced that such museums will play an important part in the medical education of the future, with a special value for post-graduate study. Such a museum requires, as you point out, much space. It also needs ample funds and a fairly large staff of technical experts. It must draw its material from all parts of the world and be kept absolutely up to date. I would suggest that in London one central museum of this type, available to all teachers, would be far more likely to prove effective than a number of separate units.

I was gratified to read the letter from "Uncle Harry," but feel that he does me too much honour. I have merely built on the work of others. Jonathan Hutchinson visualised such a museum and collected much interesting material; Andrew Balfour, that great pioneer in tropical hygiene, always stressed the value of this visual method of teaching, more especially for those going to the tropics. I was fortunate enough to be given the opportunity to develop and extend his system so as to cover all diseases. My inspiration has come from many sources, and not least from a careful study of our hospital museums. I imagine that if we go far enough back we can trace the idea to the time when "King" Harrison selected Joseph Towne to prepare your unique collection of wax models, and Thomas Hodgkin busied himself with the development of the Guy's Hospital Museum.

Yours, etc.,

S. H. DAUKES, Director.

The Wellcome Museum of Medical Science.
183–193, Euston Road, N.W.1.

Rugby

AT Honor Oak Park on March 20th LONDON DISTRICT were beaten by 2 goals and a try (13 points) to a try (3 points).

Guy's were considerably disconcerted by the spoiling tactics adopted by London District, and the frequent stoppages, rightly or wrongly, for infringements during the first half. There were some bright spots from Guy's point of view, particularly the play of N. K. Macrae-Gibson, very sound in defence, rarely caught in possession, he was the best three-quarter on view. Ziervogel, who came in for Albers, made an amazing come-back. He last played for the Hospital in 1937, but his strength, skill and judgment has not been impaired by the passing years. Hilton, in place of Batty-Shaw, was a good open forward, but one would like to see him packing more square. Boyd, deputising for Strathie, varied his play with short bursts and a punt ahead, which might have been productive but for the keen tackling of Rowlands, the opposing stand-off, who was also responsible for preventing Micklem making use of the few chances that came his way. Lillywhite and Lewis frequently kept Guy's on the attack with some faultless touch-kicking.

From a sound forward rush Willcock made a smart break and a pass, which sent Vidot over for the first try. N. K. Macrae-Gibson outwitted the defence with an elusive run for the second try, which Lewis converted, and midway through the second half he picked up in the loose, his brother, " A. C.," racing at full speed, took the pass for another try and again Lewis converted. In the closing stages, Lieut. Robertson scored an unconverted try for the visitors.

Team.—T. L. T. Lewis; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. C. Boyd, J. N. Micklem, W. H. Lillywhite, R. D. Willcock, B. H. Wilshere (captain), A. B. Lee, R. G. L. Brittain, C. Ziervogel, D. L. Gullick, S. M. Hilton, C. Vidot, P. D. F. Harvey.

In the return game against WASPS, which took place at Honor Oak Park on March 27th, the Hospital were beaten by 1 goal and 2 dropped goals (13 points) to a try (3 points).

Albers and Batty-Shaw returned to the pack in place of Ziervogel and Hilton, and Vann deputised for Willcock. Strathie's continued absence, through injury, is a severe blow, as the attack lacks *finesse* and penetration, and the resolute tackling and backing up of the Wasps still further reduced the number of scoring chances. The forwards put up a strong fight against the Wasps' formidable pack, especially after Brittain was compelled to retire after twenty minutes' play through injury.

Lillywhite took advantage of a dropped pass by Wasps and dribbled for Vidot to carry on the movement and cross for an unconverted try, which his excellent all-round play thoroughly deserved. From a punt ahead, and a lucky bounce, Angelman raced up to cross for Clarry to convert for the Wasps.

ROSSLYN PARK were the visitors to Honor Oak Park on April 3rd and ran out winners by the narrow margin of 1 penalty goal and 3 tries (12 points) to 1 goal and 2 penalty goals (11 points).

Being the last game officials were elected for next season which resulted in A. B. Lee being elected captain, C. Vidot, Vice-Captain, and A. Batty Shaw, Hon. Secretary.

Outweighted and out-hooked Guy's forwards tackled like demons to prevent the dangerous Park attacks from developing, and it was not their fault that a Park player broke through now and again. They were so fast in the loose that the Park were given no time to think, and a player in possession was promptly tackled.

J. R. C. Matthews, the old Guy's forward, played very well for the Park and scored their first try, but Lewis equalised with a penalty, which was followed by a similar score for the Park by Frank.

Following the interval exchanges continued to be even, although the Park outsides were more dangerous, but N. K. Macrae-Gibson, with speed and swerve, rounded the full-back for a grand try, which Lewis converted. Cooper's weight and vigour carried him through for a try, and when Frank kicked a penalty goal, and Naylor, with a neat run, a punt ahead, a clean pick pick up crossed for a try, the game seemed lost. Lewis crowned an excellent display by kicking another penalty goal, and it was only right that he and N. K. Macrae-Gibson should share the scoring as they were the most polished players outside the Guy's scrum.

Sayings and Quotations of Sir William Osler

The Leaven of Science, Wistar Institute of Anatomy and Biology of the University of Pennsylvania, 1984.

When I think of Leidy's simple life, of his devotion to the study of Nature, of the closeness of his communion with her for so many years, there recur to my mind time and again the lines—

"He is made one with Nature : there is heard
His voice in all her music, from the moan
Of thunder, to the song of night's sweet bird ;
He is a presence to be felt and known
In darkness and in light, from herb and stone,
Spreading itself where'er that Power may move
Which has withdrawn his being to its own."

Hospital Information, etc.

Notice

The Editors wish to thank those who are sending back their copies of the *Gazette* for further distribution, and trust that everybody, even students, will do their best to help in the saving of paper. Please pass on your copy of the *Gazette*.

Pass List

CONJOINT BOARD.

FIRST EXAMINATION.

March, 1943.

Anatomy.

D. F. V. Brunsdon	F. W. R. Seward
C. C. Bull	G. W. Scott
D. A. Harris	A. J. Swann
B. H. de C. Prideaux	J. T. Woodall

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UNIVERSITY OF LONDON.

SECOND EXAMINATION FOR MEDICAL DEGREES.

March, 1943.

J. A. Beale	P. A. W. Lea
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P. Coling	I. A. H. Munro
M. B. Conran	C. R. Neve
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Guy's Hospital Medical School

PRIZE EXAMINATIONS.

March, 1943.

The following awards have been made :—

Michael Harris Prize in Anatomy.—J. C. Crook.

Embryology Prize.—J. C. Crook and I. A. H. Munro (bracketed equal).

Wooldridge Memorial Prize in Physiology.—J. Luder.

Change of Address

F. E. Barlow, L.D.S., R.C.S., 5, Greenhill Avenue, Luton, Beds.

D. R. Finch, L.D.S., R.C.S., 164, Fore Street, Hertford.

G. K. Lacey, Surg.-Lieut.-Comdr. (D.), R.N.V.R., H.M.S. *Wildfire*, c/o G.P.O.

M. A. Partridge, Surg.-Lieut.-Cmdr., R.N.V.R., 64th General Hospital, c/o G.P.O.

Births

THOMPSON.—On March 5th, 1943, at Oxford, to Inge, wife of R. H. S. Thompson, D.M.—a son (Robert Henry Stewart).

WILSON.—On April 10th, 1943, at 8, Old Castle Road, Salisbury, to Mary (née Rooker Roberts), wife of Surg.-Lieut. Colin W. Wilson, R.N.V.R. (overseas)—a brother for Patricia.

Deaths

BLIGH.—On April 10th, 1943, at 21, Dunkeld Road, Bournemouth, Lilian Josephine (née Lafone), late "Sister Accident," Guy's Hospital, wife of William Bligh, O.B.E., M.D., aged eighty.

SAUL.—On March 9th, 1943, Edward Royston Saul, L.D.S., R.C.S., of Sneyd House, Fareham, Hants.

WESTON.—Previously posted missing in Malaya, now reported died in Singapore, February 14th, 1942, W. F. J. Weston, Lieut., R.A.M.C. (of Guy's and Croydon), only son of the late Mr. F. G. Weston and Mrs. M. Weston, Elmar, Pontnewydd, near Newport, Mon.

EDS. { P.F.E.B. J.O.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THIS number of the *Gazette* is that usually devoted to books and new publications in particular—in fact, our Literary Supplement. Many and varied are the books that are produced nowadays, and even in war-time very little change has taken place, on the whole, from the peace-time programme of the big publishing firms. Besides the swarm of pamphlets, booklets and books on subjects especially devoted to war-time subjects, there seems to be an ever-increasing quantity of material being put out in shortened forms. In the line of medical subjects most of the new publications of the last year seem to be in the form of small booklets. We wonder if these would have grown up into full-sized books if the war had not started.

A great many of the books that we read as students are well established. Few have lasted for generations, but most have been in print for many editions. These, the old-established favourites, need very little comment in these pages, unless some outstanding change is made in them. It is generally the new books which stir up the critic and the reviewer, although one would like to discuss how much a review helps a book, we wonder, do adverse reviews ever alter the next edition of a book ? Generally a new book gets known by word of mouth—and even the old favourites regain their popularity in this way. But even if one takes this view, reviewing is not such an easy task as it sounds. There appears to be in the mere physical act of writing a review something which begets a fine kindling of self-confidence and a deified state of mind such as less privileged persons produce with alcohol. One seems so vastly superior to the author. We must know, in our milder moments, that it behoves any living reviewer to approach X—— with obeisances. Yet when once the afflatus of reviewing informs us, and so long as we are appraising any book of X——'s, we can patronise and reprove, and put him to rights generally, without the least qualm. All this must be curbed, and one must get accustomed to the heady tipple.

On the other hand, in our experience, the author always does enjoy talking to his reviewers. An author likes, most naturally, when the review has been favourable, to meet a person of marked intelligence ; if, to the contrary, the review has belittled and excoriated, then does the author enjoy meeting the writer for less noble reasons. Who was the Great Man who said, when first catching sight of his reviewer, " And it was this creature, it was this material error, this ort, which spoke belittlement and vitriol and all reprobation as to my genius ! "

We shun the thought of laying down any rules for writing a book—let alone reviewing one. But we would like to say that the books that we have seen during this past year of war have been well up to peace-time standards as to lay-out and paper ; in fact, were it not that the war-time quality of paper might be rather fragile we rather prefer the matt surface to the shiny, glossy pages of old, when one had to have the light just right or else the words began to dance across the page in a general haze after a few moments.

IT is with the greatest regret that we hear of the death of Mr. Lambrinudi, orthopædic surgeon to the Hospital. A tribute to his memory will be found in the following pages, and fuller notices will appear in the next issue.

WE should like to bring to the notice of readers an article published in *The Hospital*, entitled " Guy's Hospital—The Air Raids of 1940-1941," by Mr. Lees Read and Mr. Nelson Burgess. A limited number can be obtained from the *Gazette* office at 2*s.* 6*d.* each, the entire proceeds of which will go towards the funds of the Hospital.

Four Cases of Epilepsy

By MAJOR H. F. LUNN, R.A.M.C.

THE soldier to-day is being given an ever-increasing degree of responsibility. Even a temporary lapse of concentration may endanger, not only his own life, but also the lives of his colleagues. The Army medical authorities have, therefore, always issued strict instructions regarding the disposal of epileptics, as epilepsy is one of the few conditions which can render an otherwise fit man ineffective without warning, and at any time. The diagnosis and detection of epilepsy may, however, prove extremely difficult. Even cases having repeated major fits have sometimes evaded detection. The patient may have his fits at night and be unaware of them himself. He tends to make light of any accompanying troubles such as headaches and involuntary micturition, and may deliberately conceal or deny their existence in order to prevent the diagnosis being confirmed. The mild case with only occasional major fits is the most difficult to detect and, as he tends to remain at large longer than the serious case, is a source of greater danger to his colleagues. During the past year I have had to deal with four cases of this type of epilepsy, and because of the unusual features which resulted in their detection, I will give an extract of the history of each case.

CASE 1.—*Trooper M——, aged* 38.—A bus conductor in civil life. He had a major fit when thirty-five, but was able to continue with his job and joined up at the outbreak of war. He was a reservist and had served six years in India between 1925 and 1931. He had suffered from no disease while abroad. He must have had two or three fits since joining the Army, but they had not been witnessed by anyone able to report the fact. What was worrying him, however, was an increasing difficulty of concentration and frequent headaches. One day, in his unit barrack room, he had a severe *grand mal* and was unconscious for about two hours. On the next day he came under my care. He was apathetic and responded slowly but accurately to questions. He had slight photophobia, wrinkling of his forehead, absent corneal reflexes and Argyll Robertson pupils. He was tatooed all over and was aware of small subcutaneous lumps in his arms and shoulders. One had been removed a year previously, the report showing presence of "simple fibromatous tissue." He remembered that while in India, one of the wives on the station suffered from tape-worms. The diagnosis lay between G.P.I. and cysticercosis. The latter diagnosis was confirmed at the military hospital to which he was finally admitted.

CASE 2.—*Sapper B——, aged* 26.—An entry had been made in this man's medical history sheet, when he first joined up, to the effect that he had a fit at the age of fifteen. He claimed that he had had no trouble since and, as otherwise healthy, was accepted for general service without question. He was serving with a first line field unit and was well up to standard. For over a year he was one of the company despatch riders, and was acknowledged to be sensible and reliable in the carrying out of his duties. One day I heard he had been admitted to hospital suffering from concussion. While on a long journey with his motor-bicycle he had collided with a car at a crossroads, and the evidence pointed to his having taken the crossroads without slowing down or seeing that the road was clear. His commanding officer, after study of the evidence, considered he was to blame, and the case was due to be dealt with by the police. His error of judgment was so great and so unexpected that I began to question him closely on the details of the accident. He had begun a long run early in the morning, and had stopped by the roadside "feeling faint." A lorry passed him as he stood by his machine. He pulled himself together, remounted, caught up the lorry and overtook it. He remembered vaguely approaching a car on the crossroads, but nothing else. There was nothing conclusive in his story, but when I asked him if he had ever "felt faint" before on his motor-cycle he, reluctantly and under pressure, disclosed a history of repeated attacks of "faintness" very suggestive of *petit mal*. Each attack was preceded by a definite aura which gave him time to stop his motor-bicycle and to wait until it had passed off. He must have had hundreds of such attacks, each followed by a headache and a period in which he found it difficult to concentrate. In civilian life he was a milk-roundsman and was able to pause and lean on his cart when the attack came on. He had had several major fits, but all at his home and which had not interfered with his job. His wife was becoming worried because he was subject to "moody turns," as she called them. He would sit in front of the fire, and for a few minutes would look straight in front of him not answering any questions. When back to normal again he would not remember anyone having spoken to him, and would not have been aware that anything had been amiss if his wife and children had not

told him. One further point was noted by my orderly, Lance-Corporal J. Whittle, who has had several years' experience of nursing in a mental hospital. I detained the patient for twenty-four hours in the sick bay for observation. As far as I could see he showed none of the obstinacy or intolerance of discipline often found in epileptics, but was co-operative and helpful although self-conscious. I was a little doubtful of my diagnosis of minor epilepsy, but my orderly was quite satisfied. "Typical, sir. Keeps washing his hands every ten or fifteen minutes. A lot of them do that, sir." Our diagnosis was confirmed by the neurological specialist who later examined the patient and the police-court case was dismissed.

CASE 3.—*Sergeant W——, aged* 28.—A painter by trade in civilian life. In the Army his conscientiousness and reliability earned him rapid promotion. When he joined the field unit to which I was attached he did not seem quite up to standard, and his efficiency deteriorated throughout the three months he was with us. He was referred to me because in the sergeants' mess he was noted to have "blank periods," when he seemed to lose touch for a few seconds with what was going on. He would pick up the conversation again afterwards and did not seem aware of his lapse. He seemed to fall over very easily, but although he always gave an explanation for his fall, he was vague when questioned closely. He fell over a tree-trunk in the black-out and bruised his head. He was not sure it was a tree-trunk, but supposed it must have been, because he found himself lying on the ground after walking along a road. He did not actually see the tree-trunk because it was dark.

My patient realised that he was not fit. His memory was poor and he was worried because he could not concentrate on his work and complete it with the same efficiency as formerly. He was subject to headaches. While on leave he collapsed when crossing a road with two companions. The experience worried him further. He attributed all his troubles to a motor-cycle accident six months previously. At first I jumped to the conclusion that the condition was post-traumatic epilepsy, in spite of the short interval following the accident. I questioned him closely about the accident. He was riding a motor-bicycle and remembered going round a round-a-bout, but knew nothing more until he regained consciousness in his billet. He was picked up unconscious by the side of the road about two miles beyond the round-a-bout. As he had been unconscious in all for about half-an-hour and had about four minutes' retrograde amnesia, it seemed that he must have sustained a head injury of some severity. His subsequent progress did not, however, confirm this opinion. He had no external evidence of bruising of the scalp or fracture of the skull. He was kept in bed by his medical officer for only two days and, at the end of a week, was back at full duty. X-ray showed no abnormality. He finally admitted that he had been subject to occasional *petit mal* attacks before his accident. I have no doubt in my own mind that he must have had a fit while riding his motor-bicycle and that his amnesia and unconsciousness resulted more from the fit than from a head injury. The diagnosis of idiopathic epilepsy was later confirmed.

CASE 4.—*Lance-Corporal B——* came to me, while on leave, for treatment of impetigo of the ear. While my orderly was applying the treatment he had a typical though brief *grand mal*. The fit only lasted for a few minutes and the patient was able to return home on foot shortly afterwards. He was not aware of what had happened. My orderly described the sequence with its premonitory cry, short tonic stage, and longer clonic stage. I was unfortunately not in the treatment room myself at the time. I interviewed his wife who was worried about her husband's "blank moments" at home. These were becoming more frequent and were much the same as those described for Case No. 2. I have not yet heard about his final disposal.

SUMMARY.

1. These four cases emphasise the need for a full history to be taken in cases of suspected epilepsy. The patient's unwillingness to admit his condition must be circumvented by detailed enquiry and by gaining co-operation of near relatives and friends.

2. *Petit mal* attacks are sometimes difficult to observe, but the associated lack of concentration and headaches may lead to the correct diagnosis if carefully followed up.

3. Epilepsy needs to be borne in mind as a possible factor in road and other accidents occurring in unusual circumstances.

4. It has been of great assistance to have the services of an experienced mental nurse who was able to live on a level with the patients and to observe and report on their behaviour.

A Tribute

CONSTANTINE LAMBRINUDI, F.R.C.S.

ONCE or twice in each generation there appears in our profession a man with certain of the qualities of true greatness. Such a one was Lambrinudi. He had that priceless gift, the power to see things anew with a vision that was entirely unprejudiced by accepted beliefs. To every problem that he tackled he brought a fresh and unbiased outlook. The result was not only the gift to orthopædics of a considerable number and variety of real advances, which have already been generally accepted, but also original and stimulating thought on nearly every subject which he touched. He had also that other quality of greatness—simplicity in ideas. All really great ideas are simple, and it is a tribute to him that with each advance that he made one's comment was the same, "How simple and obvious! Why hasn't that been thought of before?"

Among his many contributions may be mentioned his beautiful operations for the correction of drop foot, and the reverse or "calcaneus" deformity; his elucidation of the ætiology of claw toes and pes cavus and the brilliant results of the method of treatment that he evolved; his work on short hamstrings and their significance in the development of spinal deformities; his many contributions to our knowledge of the functions of the foot and toes; and his use of longitudinally placed Kirschner wires for the fixation of certain fractures.

He held that the chief function of the specialist was to explore the unchartered, or only partially understood, region of medicine, to elucidate and simplify them and return the knowledge so obtained to medicine as a whole. He held that there were no principles of orthopædics as opposed to principles of medicine. There were only principles of medicine, which in orthopædics should be applied to the restoration and maintenance of the function of locomotion, using the term in its widest sense. Always he laid stress on function as the only true guide in treatment, and not only function of the body as a whole, but also its proper functioning in relation to its social environment. It was for this reason that he attached so much importance to the Almoner's Department, and it was for the same reason that he instituted the employment of the visiting *masseuse* in connection with hospital practice—an innovation in which Guy's has led the field.

As a man he had the generosity of greatness, and the foibles of greatness, too. He could be irritated by stupidity which could not keep pace with his ideas. He could appear to be off-hand in his manner when his mind was completely absorbed in some problem, as it so often was. But he was also a most loyal and generous friend and a most delightful companion. His particular charm lay, not only in his sense of humour, which never failed him, but also in two underlying qualities which in him were absolute—his integrity and his complete freedom from any taint of jealousy. A man of many enthusiasms, his spirit rose triumphant over the handicaps and burdens which his health sought vainly to impose upon him.

Guy's has lost not only one of her most stimulating personalities, but also one of her great men, whose name will live as one of the foremost pioneers in the new orientation of thought in orthopædics.

T. T. S.

Correspondence

"CLINICAL ASPECTS OF TOBACCO SMOKING."

To the Editor of the GAZETTE.

SIR,—Anent the very interesting notes on tobacco there did not appear to be mention of effects of chewing.

I should be interested to know whether my impression that excessive chewing is a frequent concomitant of sciatica is borne out by other observers. And that very excessive cigarette-smoking is more likely to produce brachial neuritis.

I have had two queer cases. One man committed suicide by drinking a filtrate of tobacco—very rapid. And one chewed so continuously—even sleeping with a "quid" in each cheek—that a typical anæmia of "pernicious" characteristics developed. Great energy was devoted to treatment with liver extract injections, and even more to separating the man from his "quids" (meaning tobacco); he was a panel patient.

He gained four stone in three months and has not relapsed after seven years. He says he does not chew. It seems possible he may have poisoned the appropriate stomach cells ?

Yours, etc.,
G. W. DRYLAND.

Kington, Herefordshire.

To the Editor of the GAZETTE.

SIR,—I would like to add to Dr. Hardy's interesting and valuable paper on the "Clinical Aspects of Tobacco Smoking" brief mention of the irritating effect on the bronchial tree. There is no doubt that smoking, by causing a mild chronic bronchitis, increases the chance of post-operative chest complications, as is shown by their greater incidence in smokers. This should be borne in mind when assessing the patient's condition before operation. A heavy smoker might be well advised to limit his indulgence or omit it entirely for a proper interval before operation.

Yours, etc.,
Guy's Hospital, S.E.1. R. C. BROCK.

To the Editor of the GAZETTE.

SIR,—I have been reading Dr. T. L. Hardy's scientific and instructive article on the "Clinical Aspects of Tobacco Smoking" in the *Guy's Gazette* for April.

I have carried my mind back forty years to the time when I was medical registrar at Guy's and students sometimes consulted me about tobacco in relation to themselves. Perhaps the advice was sought as coming from one who made his fair share of runs and scored a few goals, rather than from respect for medical knowledge.

I am not concerned with juvenile smoking—which is school-boy swank—but with the problem of tobacco smoking for the student, who has reached those years when he has the responsibility of forming his own habits.

Forty years ago I held the following maxims :—

1. Don't get a fixed tobacco habit too early in life.
2. Ration smoking and don't smoke till after tea-time.
3. Don't smoke at work ; except perhaps one pipe to settle down to reading at night.
4. Limit the usual ration if you are getting less fresh air and exercise, although you may find the temptation is the other way.
5. It is easier to ration a pipe than cigarettes.

This brings me to my present views and conclusions, in which there is nothing to change in the above suggestions, but these to add :—

6. Many wise men don't smoke at all. I never noticed that they miss anything, unless, perhaps, towards later middle age and onwards they tend to neglect the benefits of the armchair.
7. The cigar is strong and, if worth smoking, is scarcely worth the money. As a regular smoke it does not suit the young athlete. It is a restful and rationable smoke for elderly men. If the teeth won't hold a pipe, and the funds will run to it, cigars may be smoked in the spirit of Father Williams's back somersaults in the later years of life.
8. The cigarette is the great danger. The habit is acquirable young and much more quickly than the pipe habit. It is a short smoke and, like a short drink, gets handed out when a man never meant to have one. It is an unrestful smoke and becomes an urgent need of the moment, whereas the pipe or cigar is worth waiting for, until a rest may be achieved. For a variety of reasons the cigarette is extremely difficult to ration. Perhaps eight or ten cigarettes a day may be the cleanest smoke, but few people keep to this over a period of years.
9. It is comparatively easy to ration pipe smoking. It fits with time and place. The exceptionally tough guy who smokes a pipe on a round of golf is comparatively rare, and the average pipe-smoker keeps it for a rest after tea in the club-house.

10. The pipe-smoker lets himself become decarbonised when he is ill. The cigarette addict will smoke when his temperature is raised, and too early in convalescence.

11. There are exceptional men to whom no rules apply. Although this is not true of the abuse of alcohol, which always brings some penalty. There are wise men who never smoke tobacco. It seems rather presumptuous to express one's views on a problem so difficult. It is a sound dictum—attributable, I believe, to Lord Dawson—" Don't prescribe until you are called in." If I were called in, however, to advise a present-day student about tobacco-smoking I should say: " If you do get the habit, and it is going to stay with you for the remainder of your days, the pipe is the safest smoke."

Yours, etc.,

Derbyshire Royal Infirmary. HUGH BARBER.

HOSPITAL INFECTION OF WOUNDS.

To the Editor of the GAZETTE.

SIR,—Dr. F. A. Knott's interesting and practical article on hospital infection of wounds prompts me to recount some of the methods used in this area, popularly known as the South-West Pacific. I hope that the letter will be legible, for not only is a typewriter unobtainable, but the letter is written from beneath the folds of a mosquito-net, under which the stretcher has been replaced by my most treasured possession, a small folding seat.

In spite of mosquitoes, ants and beetles we try to remember our Guy's upbringing. But when we read about control of ward dust and efficient masks, we are conscious of a sense of frustration and a longing for the presence of nursing sisters, who, I am convinced, are the only people capable of training others efficiently in the art of nursing. But to return to our asepsis: our autoclave is small and its rubber washer rather the worse for the heat, but, when sufficiently stimulated by a field cooker, it generates 12 lb. of pressure and, we hope, sterilises dressings and the torn sheets whch act as guards. Instruments are boiled in a dixie on a Primus stove and the dixie lid forms the instrument tray. A stretcher, resting on two panniers, forms the operating table, and light is provided by a Coleman petrol lamp when daylight is not available. Intravenous anæsthesia is therefore essential for night operations, as ether is too dangerous. The various flying insects, particularly mosquitoes, are our greatest worry. They torment surgeon, anæsthetist and assistants, and settle gracefully on sterile equipment and wounds, and have even been known to fly into the peritoneal cavity. However, by means of numerous mosquito-nets draped over doorways and windows these friendly creatures have been largely excluded.

With regard to ward dressings I am afraid Dr. Knott would raise his hands in horror. Ward dust is a thing over which we have no control, as it comes from an incredibly dusty road and is directly proportional to the amount of transport on the road. Plaster dust depends on the wind and the vigour of the huskies who tear off plasters with our ancient shears. Wounds are treated with respect largely after the style of 1935 Guy's. Masks are worn but gloves never, and an assistant who is " bacteriologically clean " is a thing I will file in my mind for future reference.

In spite of these shortcomings and faults in technique our wounds, treated by the excision and sulphanilamide powder closed plaster technique, do as well as those treated by our well-equipped colleagues from the United States.

In conclusion, we still read and enjoy the *Gazette* and note that you can still play football. But let there be no more nonsense about equal sacrifices between civilian and Army M.Os. Danger and discomfort are exciting and the loss of a practice amply compensated by the fact of being able to look one's friends in the face after the War but let the overworked general practitioner who, after all, still has his soft bed, good food, etc., try parting from his wife and family, and I think the argument will cease abruptly.

Good luck to all at Guy's!

Yours, etc.,

J. E. GIESEN, Capt., N.Z.M.C.

2 N.Z.E.F.I.P.
N.Z.A.P. 150.

MEDICAL EXAMINATION ANSWER.

To the Editor of the GAZETTE.

SIR,—The following is from an examination answer to a question on renal tuberculosis (not in Cairo University) :—

"The difficulty rises sometimes as to which organ to remove first if the condition is bilateral. Here the first kidney, if completely affected, should be nephrectomised. In the other one, as much renal tissue should be preserved as possible. The diagnosis is poor in the last-mentioned cases."

I have got beyond the postal reach of the *Gazette* lately. I hope all goes well with you.

Yours, etc.,

Medical Branch,
G.H.Q., East Africa.

W. H. OGILVIE, Brigadier.

Sector News

Guy's Letter

THE event of the month has been the revue, "Starlet No. 3," produced by Tom Hills, which ran for two nights in the theatre of the old Pathology Building. A variety of material and talent made an entertainment whose high standard was maintained throughout. The residents' play, "Operations Continue," by S. H. Wass, was, perhaps, the outstanding feature of the show and the idiosyncrasies in word and action of the main characters produced an immediate effect on their audiences, who apparently had no difficulty in recognising the Hospital personalities represented. Of the other items three short humorous sketches whetted the audiences' appetite early on, but they, nevertheless, seemed to find Noel Coward's "Cat's Cradle" rather too subtle. "Guy's, 1950," however, went down very well despite its hint of bureaucratic regimentation and aroused much laughter—perhaps not unmingled with apprehension.

Of the individual acts Shillitoe's polished performance on the violin, especially "The Canary," was immensely enjoyable and one would liked to have heard more of him. Miss Hogg appeared as a very inexperienced V.A.D. and sang a delightful song about her troubles. A welcome visitor was Phyl Rowe, who sang to us with her usual charm about a certain physician, who, it appears, was moved to poetic utterance by an artistic appreciation of anatomical structure. Professor McWhurtle, in a voice strangely like that of Sichel, gave an interesting and highly entertaining account of the essentials of rabbit-breeding and his expedition to the Peruvian interior in '01. The slides which accompanied it gave full support to the subject of the lecture and in themselves provided a good deal of fun.

The show opened with a song by three "Men in White," one of whom brandished a large size in bougies as a kind of baton, and concluded with more singing in the shape of an alleged opera company headed by a voluble gentleman with a fierce moustache and bad English. "Sulphaniculi, Sulphanicula," an ode to the magic drug, was followed by the popular ballad "Excelsior," in appropriate costume and melodramatic form.

It was a pleasure to see so much home-produced material in the programme; and Messrs. Hills, Wass and Trethowan deserve much praise for the work and ingenuity put into the revue, which was a uniform success.

R. I. M.

Reviews

Fractures and Dislocations. A "Practitioner" Booklet, edited by SIR HUMPHRY ROLLESTON, BT., G.C.V.O., K.C.B., M.D., F.R.C.P., and ALAN MONCRIEFF, M.D., F.R.C.P. Published by Eyre & Spottiswoode. *Price 7s. 6d.*

THIS booklet represents a collection of articles by various authors which appeared in *The Practitioner*. Ranging over the common fractures and dislocations that the ordinary medical practitioner is likely to come up against, these articles outline the present knowledge of diagnosis and treatment.

Only the common fractures are dealt with and, in addition, the article on fractures of the arm includes a brief summing-up of the treatment of compound fractures and war wounds in general, a very excellent little *précis* on the modern treatment.

The longest article is that on head injuries. It is a very difficult thing to cram into the scope of a book of this type such a subject, but the difficult task is here successfully achieved.

The Revolving Heavens. By REGINALD L. WATERFIELD, M.B., B.S., M.R.C.P., F.R.A.S. Published by Duckworth & Co. 203 pp. *Price* 8*s.* 6*d.*

THIS little book, also entitled "Astronomy for Observers with the Naked Eye," does exactly what it sets out to do—to help those who have to spend their black-out hours out of doors. Probably, for the first time, large numbers of us have had to spend part of the night gazing at the sky; fire-watchers, A.R.P. personnel, Home Guard, etc., we all saw the heavens with new eyes—the heavens as we had never seen them before.

Dr. Waterfield tells us what pleasure we can get out of observing the heavens with the naked eye. And with the information obtained, what practical use that pleasurable knowledge can be put.

From the description of the heavens, with its planets and stars, the sun and the moon, we abstract knowledge as to the measurement of time and space, knowledge as to the tides, and, beyond that, a view of the whole Universe.

Having read this book we now sally forth to our nightly duties full of the confidence that one knows what one is talking about when asked how old the moon is, or whether that particular constellation is Orion or not. And we even feel that under such able tuition we would feel fairly confident to navigate a boat—as long as the stars were there to guide us.

Infant Feeding in General Practice. By J. VERNON BRAITHWAITE, M.D., F.R.C.P. Published by Messrs. John Wright & Sons, Ltd., of Bristol. Second edition. 156 pp. *Price* 7*s.* 6*d.*

THIS book represents the view of infant-feeding as seen by a general practitioner and is written for general practitioners. As Dr. Cameron says in the foreword, there is in respect of pediatric training and practice a peculiar contrast in the attitude adopted in this country and in the United States. There the child is under the care of pediatricians—here, under the care of the general practitioner.

So many of us, when newly qualified, are acutely conscious that although having a reasonable knowledge of internal medicine and of a fair variety of surgical procedures, we mostly are appalled at the thought of treating sick children and, worse still, anxious parents. Dr. Braithwaite's book does much to help us. Properly emphasising the importance of breast-feeding in his opening chapters, artificial feeding and nutritional disorders are dealt with, if not fully, at least adequately—and there is another interesting chapter on some conditions resembling nutritional disorders.

The Principles and Practice of War Surgery. By J. TRUETA, M.D. Published by Hamish Hamilton Medical Books, in conjunction with William Heinemann, Ltd., London. 377 pp. *Price* 42*s. net.*

IN this book Dr. Trueta presents an account of the "biological" method of treatment of wounds and fractures. He acknowledges in the preface that there is little new in the technique described and that his main contribution has been to combine several established principles "so that the benefits of each might be increased by their logical use in a single method of treatment." This is indeed true, for his five-point plan of treatment can be summarised as combining early wound excision with plaster immobilisation, together with a strong warning against the dangers of primary suture in war wounds. If only for its frequent insistence on these principles Dr. Trueta's book will serve a great purpose; but it has other features which commend it to all who are taking an active part in the treatment of war injuries.

There is an interesting historical account of the development of war surgery throughout the ages, in which Trueta again acknowledges his debt to such pioneers as Ollier and Winnett Orr. The pathology of infection and healing of wounds is most ably expressed in a series of chapters which can be read with profit and entertainment by all students of surgery. The chapter on shock is disappointing; this is inevitable if, in an attempt to produce order out of chaos, a number of entirely artificial subdivisions of the subject are created. The section on traumatic arterial spasm is incomplete and could well be expanded in a work of this type.

The second part of the book deals with the treatment of wounds and fractures of all types. The outstanding chapter in this part is that dealing with the details of wound excision; the subjects of primary and secondary suture of wounds are also

admirably expressed. When reading the section on regional surgery one gets the impression that it is cramped and sketchy; many of the statements, if taken literally, are open to considerable dispute. The chapter on amputations is for the most part good, but the guillotine amputation raises its head again and one other statement is so startling as to be breath-taking. After saying that the sites of election for division of bones "are now universally accepted," we are told that "the femur should never be left shorter than six inches; when this would be unavoidable it is better to do a disarticulation at the hip joint." The optimum and minimum lengths of stump in the different situations are not clearly or accurately stated and this section needs revision and expansion.

The book is excellently produced and the minor criticisms of the text which have been made should not detract from it as a whole. It is a volume worth its place on anyone's bookshelf. S. H. W.

Out of Working Hours. Medical psychology on special occasions by HENRY YELLOWLEES, O.B.E. Published by J. & A. Churchill, Ltd. *Price 8s. 6d.*

THIS book consists of a series of lectures that have been delivered by the author, in recent times, to widely different audiences. All the subjects are an example of applied psychology, but without that technical phrasing that often baffles the reader and which may serve to disguise the verbal inadequacy of the author.

Although many controversial matters are dealt with rather too dogmatically, this book contains much interesting advice. One of the longest chapters is devoted to the problems of adolescence; the information here is good, but it has the drawback that the author tends to make free use of analogy to prove his point, so the argument is not altogether convincing. One other chapter that is really good is the one that is concerned with the difficulties of women in authority. This lecture was given to a number of sister-tutors, and in it the author explains how the best may be got out of the pupils whilst maintaining discipline and without having to sacrifice friendly personal and social relations.

This book is entertaining and instructive and is well worth reading even if the reader is forced to disagree with the author in many instances. H. B. F. O.

Habit and Heritage. By FREDERICK WOOD JONES. Published by Kegan Paul, Trench, Trubner & Co., Ltd. *Price 5s. net.*

PROFESSOR WOOD JONES has devoted much effort in support of the theory of the inheritance of acquired characters. In this latest publication he returns to the theme with unabated zeal.

In dealing with a book of this nature the reviewer does not feel inclined to take sides over the theories in dispute. It is sufficient to say that the main bulk of biological opinion is opposed to Professor Wood Jones's views, and there is little chance of his latest effort altering the position.

The greatest success which this kind of book can achieve is to stimulate its readers to think for themselves. In this direction Professor Wood Jones will undoubtedly succeed. His style is clean and his arguments are easy to follow. Several of the references are also very interesting, and most Guy's men will be interested in Lane's work.

"Habit and Heritage" is well printed and the illustrations are adequate. An excellent book, well worth reading.

A Text-book of Gynæcological Surgery. By SIR COMYNS BERKELEY, M.A., M.C., M. D. (Cantab), etc., and VICTOR BONNEY, M.S., M.D., etc. Fourth edition. Published by Cassell & Co., Ltd. 912 pp. *Price 50s. net.*

THIS magnificent work has now reached its fourth edition and is a monument to the industry and knowledge of its authors. With unfailing energy they have brought the book up to date, having rewritten the sections dealing with vaginal atresia, ovarian cystectomy and other subjects; in addition, forty-four new illustrations have been added.

To the young gynæcologist or the general surgeon called upon to undertake gynæcological work this book can well act as a very complete guide, and no one can read it without learning. Gynæcology in this country owes much to Sir Comyns Berkeley and to Victor Bonney; both have been ardent teachers all their lives and here we are given the fruits of their very extensive operative experience.

Once again it must be repeated that this is a marvellous work and a copy should be owned by all those undertaking operative gynæcology.

Illustrations of Surgical Treatment. By E. L. FARQUHARSON, M.D., F.R.C.S.E. Second edition. *Price 25s. net (postage 7d.).*

MR. FARQUHARSON illustrates very successfully by photographs practical methods of surgical treatment, a subject which is not found in surgical text-books, nor is it covered satisfactorily in routine teaching. About two-thirds of the book is devoted to injuries and fractures; here methods of reduction are remarkably well illustrated and then photographs of splints and plaster casts are shown. The section on fractures and dislocations of the spine should be most useful, as all the recognised methods of producing hyperextension are demonstrated.

In this second edition the opportunity is taken of describing in detail and illustrating the methods of blood transfusion in the blood transfusion services of the Emergency Medical Service and of the Army. The book concludes with photographs of instruments and short notes on their uses; students and theatre nurses should appreciate this part of the book. F. R. K.

Essentials of General Anæsthesia. By MACINTOSH AND BANNISTER. Third edition. Published by Basil Blackwell. *Price 25s.*

THIS book gives a very adequate account of the principle upon which the technique of anæsthetics is based, with particular reference to the giving of anæsthetics for dental extractions. In the introduction to the first edition the authors remark that "the standard of administration of anæsthetics by the family doctor is a standing joke between dentists," and much of the book is therefore concerned with the technique of giving a "dental dope" to the requirements of the dental surgeon and benefit of the patient. This volume should, therefore, be of interest both to the general practitioner who finds his services as anæsthetist required by his dental colleagues on frequent occasions and to the medical and dental student in a hospital such as Guy's, where the opportunity of giving this type of anæsthetic often presents itself.

The requirements of the general surgeon are not neglected, however; and, besides the usual chapters on the theory and practice of anæsthesia, there are others on its history, on the legal aspects and on the care of an unconscious patient. It is thus comprehensive in its scope. The illustrations are numerous and simple and ably clarify the text, and the mechanically-minded will find the diagrams of reducing valves of interest. Many of them are in colour and the chapter on cyanosis is supported in a novel manner by plates coloured to show plethoric, average and anæmic patients as they appear under varying conditions of oxygen saturation and depth of anæsthesia. The tone of the book is very practical throughout and it can be recommended for its clarity. R. I. M.

A Short Survey of the Mythozoa

BY SIR ROBERT SYNJANN, P.R.D. (Lond.).

MY friend, Prof. A. Reltih, has asked me to write this article. It is now, he says, that a new appointment is beginning, and the ward clerks and pre-clinicals, walking the wards for the first time, should be warned of the manifold activities of the mythozoa.

It is a fact that our scientific knowledge of the subject is very incomplete. What facts we have are of very recent origin, and mostly relate to the specialised branch of Gremlinology. Like any new science it is disbelieved by people in general, and even the Brains Trust has placidly declared that Gremlins are figments of airmen's imaginations. Guy's, however, leading the medical world as usual, has for some time had under observation the activities of the first cousins of the Gremlins—that is, the Perklies and the Gubbins.

The fundamental fact to grasp is that the mythozoa are represented wherever there are men, and that at this hospital there are two main varieties—the surgical and the medical. A medical one is a Perkly, a surgical one is a Gubbin. Be sure not to confuse them, as they are rather sensitive about their names. The actual origin of the names is obscure, and they are not found in the dictionary, but recent investigators say that "Perkly" comes from a near-by brewery which provides free beer and a subsistence dole for poor students. "Gubbin" is more difficult. It is probably not their true name, but Prof. Reltih's nickname for them, which has stuck.

Like all the mythozoa they have developed the capacity for evolution to an astonishing degree. If they want a part for performing a certain action they just grow

it. As an instance of this, a nurse in Surgical Out-patients actually saw one do so on Boxing Day. It was climbing up the anæsthetic machine when she first saw it. When it got to the top it grew a spanner, quite quickly, on the end of its flap-like arm and proceeded to let the gas out of all the cylinders, jumped down and ran away. The nurse, quite erroneously, classified the phenomenon along with pink elephants she remembered the previous night, decided that was the cause, and prepared to forget the whole incident. But, sure enough, on the next day for minor operations, all the cylinders were empty.

Watch out for your Personal Gubbin (or Perkly). He is a creature of many tricks. The favourite one is getting behind you when you are assisting at an operation, and making your arm shake for all he is worth. When you are trying to undo a pair of artery forceps, you will find he has locked them together, and when you are cutting a stitch, he waits for the crucial moment, then gives you an almighty jog, so that you cut the whole thing off, knot and all.

To return to Perklies. Perklies, on the whole, are not as bad as Gubbins. The worst they do is to make a vein disappear when you are trying to put a needle into it. Otherwise they confine themselves to altering case notes so that they sound foolish when read out by the registrar, holding pieces of frosted glass in front of ophthalmoscopes, and growling in your stethoscope when you are listening to a heart. There are ward Perklies as well as personal Perklies. These are usually very specialised. For example, there is one in Wilks, who specialises in doping patients so that they are about the World's Worst Witness (he is known as the W.W.W. Perkly) just before you take the history. Incidentally this Perkly is responsible for all the blunt needles in that ward. He grinds down the points with a special stone. There is another in Bright, who puts screens in front of the entrance just when you want to go in there. Dr. K—— tells me that a tiny Perkly over in the bacteriology laboratory seems to exist for the sole purpose of putting *B. proteus* on to agar plates; and Dr. L—— is often told about the Perklies who spread infectious material on to bicycle saddles and w.c. seats.

Gubbins, as was said above, are a more serious proposition than Perklies. They seem to act partly out of a sense of duty, so often do they get to work. You will remember that trouble we had recently in Mary. Steriliser always either—(*a*) empty of dishes and full of water, or (*b*) full of dishes and empty of water. The Mary Ward Gubbin did that.

Addison has for some time been without a ward Gubbin. This is made up to a large extent by the unhampered activity of the dressers' and nurses' personal Gubbins. A Gubbin frequently sprouts agar plates instead of hands and feet and, after walking all over dirty floors and waiting twelve hours in the incubator, so that microbes grow there, he walks in a flat-footed fashion over to some patient newly back from the theatre, pulls back the gauze, exposes the incision, and puts his finger in it. If he doesn't put his finger in he puts his foot in it—a well-known surgical maxim, Mr. Ward Clerk, which proves the point.

Then there are the theatre Gubbins. These are like the ward Gubbins—*i.e.*, thin and conscientious, except that they wear green gowns instead of pin-stripes. There are very, very many of them. It is sometimes amazing what trouble they can cause. Some knock the glass stitch containers out of the nurse's forceps, so that they crack on the floor. Others, more vicious, but still very pleased with themselves, abstract the sucker just when it is urgently needed. Others, again, specialise in blunt knives and scissors and cut half way through pieces of catgut.

Should any readers of the *Gazette* with personal experience of the mythozoa be so inclined, they are earnestly asked to write a letter to this journal, as the author of this article is very interested (he has had cause to be) in their doings.

Rugby

UNITED HOSPITALS SEVEN-A-SIDE COMPETITION.

THE United Hospitals held their fourth war-time seven-a-side competition at the Athletic Ground, Richmond, on April 10th, before a large crowd, who were rewarded with an excellent final between St. Mary's and Middlesex. These two sides have been the finalists since the competition was inaugurated, and for the third time St. Mary's were the winners this time by 11 points to 5. They had much to thank T. A. Kemp, who skilfully avoided several tackles in scoring two of the tries.

Guy's drew a bye in the first round, which brought them against St. Thomas's in the second, whom they defeated by 10 points to nil, with tries by Lee and Strathie, both of which Lewis converted.

The semi-final against Middlesex was the same old story, the masterly hooking of Steeds turning the scales in their favour and, as a result, Guy's backs saw very little of the ball. As constituted, Guy's forwards lacked that extra snap and vigour so essential in sevens and the backing up all round left much to be desired. Davies crossed for Middlesex in the first period for McIver to convert and held on until the last minute, when N. K. Macrae-Gibson scored a nice try, but too far out for Lewis to convert. In sevens, Guy's flatter only to deceive. They need more height and weight forward to have any chance in the line-outs, and at least one strong and speedy runner in the backs to finish off the attacks and to back up Strathie.

Team.—T. L. T. Lewis, D. M. Strathie, W. H. Lillywhite, N. K. Macrae-Gibson, B. H. Wilshere, A. B. Lee, P. D. Harvey.

RESULTS.

1ST ROUND.

Middlesex	5	London	0
University College Hospital	6	Westminster	3
Bart.'s	10	King's	0

2ND ROUND.

Guy's	10	St. Thomas's	0
Middlesex	18	Charing Cross	0
University College Hospital	13	St. George's	5
St. Mary's	10	Bart.'s	0

SEMI-FINAL.

Middlesex	5	Guy's	3
St. Mary's	18	University College Hospital	0

FINAL.

St. Mary's	11	Middlesex	5

MIDDLESEX COUNTY SEVEN-A-SIDE TOURNAMENT.

Guy's entered two teams in the Middlesex County sevens and both were beaten in the first game they played. The 2nd Seven went out to Old Fullerians by 9–0 on the Wasps Ground in the first round.

The 1st Seven were exempt to the fifth round (finals day), held at the Athletic Ground, Richmond, on April 24th. Unfortunately, Oxford University scratched and Guy's had a walk-over to the sixth round, where they met Middlesex Hospital.

Two changes were made from the side beaten by Middlesex in the Hospitals sevens, Micklem and Vidot replacing Lillywhite and Harvey respectively, and although Guy's were much stronger forward, the back division were terribly disappointing. Middlesex opened the scoring, when McIver dribbled over from a dropped Guy's pass, but Lewis equalised by forcing himself over for an unconverted try. Early in the second period Guy's dropped another pass and McIver picked up to score under the posts, and Swanson brushed aside all opposition and left three Guy's men prostrate on the ground for the final try, which gave victory to Middlesex by 9 points to 3.

Middlesex put up a strong fight against St. Mary's in the final, but had to admit defeat by 8 points to 3.

Guy's Team.—J. N. Micklem, D. M. Strathie, T. L. T. Lewis, N. K. Macrae-Gibson, C. Vidot, A. B. Lee, B. H. Wilshere.

Hospital Information, etc.

Notice

MIDWIFERY REGISTRAR.

Applications are invited for the post of Whole-time Registrar (Male) in the Midwifery Department. Duties to commence as soon as possible. Salary £250 per annum. The Registrar will be required to assist in the teaching of medical students, for which an additional honorarium of £100 per annum will be paid. This appointment is approved by the Central Medical War Committee as a B 1 post. Applications, stating age, qualifications and experience, and accompanied by not more than three testimonials, should be sent, as soon as possible, to the Superintendent, Guy's Hospital, London Bridge, S.E.1.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

PRE-MEDICAL AND PRIMARY EXAMINATIONS.

April, 1943.

Materia Medica, Pharmacy and Pharmacology.

K. R. J. Coates — E. D. C. Jones
R. A. Leeming

Physiology.

J. Bunyan — K. Y. Khong
A. J. Swann

EDS. {P.F.E.B. J.O.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVII. No. 1430 *15th May, 1943* *Ninepence*

PASSIM

IT is without apology that we return to a subject that figured in our discourse a month ago. The subject is tuberculosis, and so much activity is taking place at present in regard to preventative measures that it is no easy business to keep up to date with the latest advances. This week one great step has been taken that may well affect the success of treatment as much as a great medical discovery, although it actually originates from a Government department. It has been decided to make cash allowances to those diagnosed as tuberculous, to enable them to stop work and undergo suitable treatment without leaving their dependants destitute. In the past it has undoubtedly been this factor that has prevented the full realisation of medical hopes in the cure of this disease. Except in village colonies such as Papworth and Preston Hall, where suitable work under medical supervision could be provided, there was nothing between full work and retiring from the world for an unknown length of time, leaving all one's family dependent on charity or the rates. And what man would consent to the latter as long as he could work at all. The fact that he was all the time spreading his disease, as well as forfeiting his ultimate chance of cure was too distant to compete against the present realities. The new allowances are by no means excessive, but they are not to be subject to a means test and may also be augmented by the local authority who administers them, in suitable cases. We must, therefore, welcome them as an advance along the right lines, although not the ultimate goal, which must be rather an extension of the residential colony to cover all cases and all needs.

Another aspect of the problem which is still lost in a fog of verbiage, however, is that of the pasteurisation of milk. There has been some acrimonious correspondence in the medical press, and various question have been asked in Parliament with answers which were, to say the least, uninformative. We should make up our minds on the subject which is one of considerable importance, since it affects not only the medical world, but also the whole structure of the milk distributing trade, and the farmers. It must be realised that compulsory pasteurisation will not be easy to put into practice ; those who live in the country will know that to continue the present system whereby small producers market their own milk locally in most instances, only the big towns receiving a pooled milk supply, will almost certainly be impracticable. The crux of the matter is that if pasteurisation is to be employed it must be efficient. And to be efficient it must be done by those with specialised knowledge or, at least, be carefully supervised by them. And this in turn means that small plants are not practicable and that milk must therefore pass through large collecting and pasteurising centres to be redistributed later to the areas, among others, whence it came. If, therefore, compulsory pasteurisation is to be introduced two points must be settled. First, the medical profession must really decide whether they as a whole agree with the experts that it is necessary for the health of the nation. And if, and when, this is achieved they must then convince the rest of the country that they are right. In no other way will it be possible to effect the necessary changes without great opposition from those affected by them—opposition which, though it may be overcome by forceful measures, will of itself delay the success of the scheme or even jeopardise it. Think about it, then, because it will need all the thought we can give it before the question is settled.

Finally, we are pleased to draw the attention of our readers to a meeting of the National Association for the Prevention of Tuberculosis, to be held at Tavistock House North on July 28th, for one day only. It will deal with the new Mass Radiology scheme, and with the question of financial allowances for the tuberculous. The Minister of Health will open the conference.

SOME time ago we asked our readers to help us to save paper by returning copies they have finished with to the office of distribution and by sharing one copy between several. There has been some response to this request, but, in spite of it, you will notice we have had to cut down the size of this issue. So any further saving will be appreciated, and may help us to maintain the present size of the *Gazette*.

Letters to My Nephew

By "UNCLE HARRY."

MY DEAR GUY,—I suppose it's no good telling you that you are an owl to to get malaria because I know that, living under active service conditions, it is not always possible to shelter under a net at night. But it *is* possible to use repellents and common paraffin is always obtainable and is one of the best—and one of the nastiest. So on second thoughts I *still* think you are an owl, because I told you about it before.

In my last letter I said that the two diseases with which every Service medical officer should know thoroughly are dysentery and malaria. You've had both of 'em now, and there is no better way of learning something about them.

Malaria is so big a subject that the wallahs who specialise in it call themselves "malariologists"—an ugly name! I cannot hope to say much about it in a letter, but knowing the failing of many students to skimp diseases which "we don't get here," it can do no harm to run over a few points.

You probably remember the varieties:—Benign tertian, caused by *Plasmodium vivax*, which has a 48-hour life cycle; subtertian, caused by *P. falciparum*, with a life-cycle of 24–48 hours (remember this!); and quartan, which is caused by *P. malariæ*, with a 72-hour life-cycle. There is really another variety called "ovale tertian," due to a parasite which has been called *P. ovale*, because it and the corpuscle which contains it tend to assume an oval shape. It has a life-cycle of 48 hours and, clinically, is only a short-lived sort of B.T. I often wonder whether it deserves the distinction of a special name of its own.

A paroxysm of malaria is caused when the parasite sporulates, comes to maturity and bursts, setting free the merozoites and hæmozoin or pigment. It is probably the latter which acts as the toxic agent. B.T. and Q.M. sporulate in the peripheral blood, but S.T. sporulates in the visceral capillaries. That is how some of the varities of S.T. are caused, by massive "swarming" of the schizonts in one or other of the viscera. Hence the pulmonary, cerebral, cardiac, dysenteric and choleraic varieties, as well as malarial amblyopia.

If you ever see the schizonts of *P. falciparum* in the peripheral blood it nearly always means a massive infection and a bad prognosis, for they have been "crowded out" of the capillaries in which they would normally undergo schizogony.

I have told you before that B.T. parasites have been likened to a well-disciplined army, which marches in step and fires volleys only on word of command. That is to say that all the parasites develop simultaneously and set free their merozoites at the same moment, together with their hæmozoin. This explains the sharp, clear-cut temperature of strict tertian type, followed by a day of remission. But S.T. parasites have life-cycles of anything from 24 to 48 hours, so they are setting free their merozoites at all sorts of odd times; and although the tertian character of the temperature may predominate and be recognisable, you never get the complete remission on the second day as in B.T., because there are usually enough parasites pooping-off to keep the temperature up. That is why they have been likened to an ill-disciplined army or mob marching out of step, and pooping-off their rifles as and when they feel inclined. In quartan you get the same clear-cut temperature as in tertian, but with two days of remission. Is that clear?

But a patient may become infected with all three varieties, and that is inclined to mess things up as regards clinical diagnosis. What is more, in an intensely malarial area he may be affected with several crops of each, each going through its customary cycle irrespective of the others. Thus we may have "mixed" infections and "double infections"—quite enough to take the grin off your face if you have to treat such cases. For the sake of simplicity take a case of double B.T. in which one crop of parasites matures a day later than the other. Call them A and B. On the day when A is having a stand-easy and there would be a remission, B boosts up the temperature. When B has done his stuff A starts again. Thus there is a *daily* rise of temperature and no remission. To this the name "quotidian" malaria was once applied; but you had

better forget it, bacause I have met men who thought it was another separate variety of the disease. It is merely descriptive of the character of the fever.

Quartan malaria is less widespread in its distribution than the other two and you may never see a case. It is the kind which is generally prevalent in the Andaman Islands and the areas in which it is endemic are usually limited and circumscribed pockets. At the Arab village of Nefisha, near Ismailia, I found all three varieties.

You might be asked to investigate the prevalence of malaria in a district and it is useful to know how to set about it. It is done by determining the "splenic index" of the community. The inhabitants of a very malarious area develop a certain immunity and their spleens diminish in size. Therefore children between the ages of two and ten are investigated. The infantile spleen-rate *per cent.* is the index of malariousness. The children may be examined either lying or standing, but higher values are found in the lying position. The degree of enlargement is classified in finger-breadths below the costal margin. As there may be fallacies in this method due to the shape of the child's chest, another method is to measure from the costal margin to the apex of the enlarged spleen. A more accurate method is to determine the parasite-rate in thick blood films, which requires the means for staining and examining the films. In adults it was found that 23.5 per cent. had positive blood films who only gave a spleen rate of 3.03 per cent., and, in children, of two thousand, who gave 50.52 per cent. of positive films, only 3.03 per cent. had palpable spleens. It is important to remember that spleen-rate falls with age, and that rates for adults and children should be kept separate. Parasite-rate falls more slowly. It shows the adults who are "healthy carriers."

As regards diagnosis, this must rest finally with the laboratory. Always take a blood-slide before you give any anti-malarial treatment, even in the class of cases I mentioned in an earlier letter, "Sunstroke or cerebral malaria?"—in which 10 to 15 grains of quinine bihydrochlor. should be given intravenously as soon as the slides have been taken. But if you have no slides just give quinine and send them to hospital with a chit, saying what you have done and why.

Periodicity of the paroxysms, as well as their character, may help you to a diagnosis, but *always take a blood-slide before quinine.* It is even better to take two slides in case one should be a dud—and don't forget to put the patient's name on them. Always look for an enlarged spleen.

There is so much to be said about malaria that I think I had better leave you to read it up and take every possible opportunity for seeing cases.

I will conclude with a story of the days when the mosquito was proved to be the vector. Infected mosquitos were sent by parcels post in a small cage from the Roman Campagna to London. Young Pat Manson, who was a student at Guy's, volunteered to be bitten. A laboratory attendant named Warren also put his arm into the cage and was bitten. Both developed malaria in London. Manson, Senr., Low and Sambon wanted the Colonial Office to give their financial help to erect a mosquito-proofed hut at Ostia, one of the most malarial districts of the Campagnia. An official at the Colonial Office said "Rubbish! Mosquitos have nothing to do with it. Malaria comes from breathing bad air. *That is what the name "malaria" means!*"

He was asked whether he would consent to be bitten by an infected mosquito sent by post to London, and readily agreed. But when it came to the point he funked it and refused. As everybody knows, the help of the Colonial Office was at length obtained and Sambon and Low with Mr. Terzi and their servants lived in a netted hut throughout the malaria season, retiring to its protection at sundown, without contracting the disease. Young Pat Manson was in the Guy's XV and died as the result of a gun accident on Thursday Island.

We have just had a letter from your cousin Dorothy stamped "Damaged by sea water." It was evidently in the Clipper which went down at Lisbon and is almost illegible, thanks to these water-soluble methylene-blue inks. She is well.

Here is your aunt, who joins me in best love, calling me to tea. So I will remember whose uncle I am and try to keep out of the hands of the police!

Your affectionate,

"UNCLE HARRY."

The British Dental Students' Convention

(Southern Regional Council)

HELD ON 9TH AND 10TH APRIL, 1943, AT GUY'S HOSPITAL.

THIS was the first B.D.S.A. Convention to be held in this country and its aim was to give students an opportunity to meet one another and to hear authorities on dental subjects whom they would not in their normal course of studies have the facilities of hearing. A large and appreciative audience attended, including many students from the provinces. The following is a brief *résumé* of the various items :—

THE DENTAL ASPECTS OF PLASTIC SURGERY

BY SIR HAROLD GILLIES.

In the Chair : F. BOCQUET BULL, F.R.C.S., L.R.C.P., L.D.S.

Sir Harold Gillies said that it was his duty to the dental profession and the erupting members of it here present to point out the very great advances that the prosthetic surgeon has made under his own steam and under the stimulus of his surgical colleagues. Not only does the surgeon produce problems to be solved by his dental colleague, but the latter shows the surgeon new methods of fracture control and prosthetic appliances which are to find their place in the schedule of treatment.

Sir Harold continued : " It has always been my aim to work very closely with the dental surgeon so that he is part of the team—a man with his own opinion and his own clinical judgment. A surgeon can remove a tooth, but he is a fool if he does. He may dispense with the services of the prosthetic surgeon and fail to get an adequate appliance prepared in advance of the operation. Consequently he will have to temporise on the table with results which are not always satisfactory, and in any case jeopardising and making more difficult the aftercare by the dental surgeon, of the skin grafted cavities. But the dental surgeon must also beware. He sees a surgeon draining a case of fracture ; he sees him wire the fracture by open operation, and he is tempted himself to undertake these sometimes simple and sometimes advisable operations only to find that he runs into difficulties or applies the treatment in a case in which such treatment is not indicated.

" I cannot emphasise too much the very great share of the credit the dental surgeon should take in such and similar cases. Only by his persistent and meticulous care can the results, often spectacular, of the surgeon's work be brought to a final and lasting success."

Three patients were then demonstrated, together with a film of a complete surgical operation involving the introduction of a complicated prosthetic appliance into a skin-grafted cavity. Colour photos of bomb wounds and the application of the two-pin fixation method in cases of fracture of the mandible were also shown and explained.

A DISPLAY OF DENTAL FILMS.

The students were shown a number of films lent by Dr. E. W. Fish and Mr. C. Bowdler Henry.

Mr. H. Mandiwall then presented his magnificent colour film on the preparation of porcelain jacket crowns and recommended very strongly that every student interested in photography should join the B.D.A. Photographic Society.

DENTAL JURISPRUDENCE.

BY J. A. LE BRASSEUR.

In the Chair : Professor E. SPRAWSON.

Mr. Le Brasseur, of the London and Counties Medical Protection Society, dealt first with law as applied to the student. He said that in the eyes of the law a student is responsible for his own acts and can be held responsible. The question, " Is anyone else responsible ? "—viz., the Dental School Authorities or the dental surgeon if in charge of the student, but this has never been tested in the courts ; the surgeon, if in attendance, could not be held responsible if it could be shown that reasonable care had

been exercised. The case was quoted where a fourth-year student had administered an anæsthetic which had led to the death of a patient. Both student and surgeon were exonerated from blame, since reasonable care had been taken. Mr. Le Brasseur then dealt with what he called the practical side. He gave three pieces of advice to the student on qualification :—(*a*) Join a protection society immediately ; (*b*) apply to the sheriff's officer of the county for exemption from juryman's duties (exemption is granted for practising dentists, but only if application is made); (*c*) take out insurance for third party risks and employer's liability.

Mr. Le Brasseur then spoke on the dentist as a witness and said that all evidence should be delivered as briefly and sincerely as possible, in order to overcome the spontaneous feeling of sympathy for the plaintiff in judge and jury cases where the dentist is the defendant. Simplicity is the hall-mark of the successful witness. He referred to a case about to be brought up in the courts which may make dental history in which it is to be decided whether a denture is part of dental treatment or whether it is to be classed as " goods sold to the public."

THE PSYCHOLOGICAL TREATMENT OF CHILDREN.

By Lieut. Calvin Coggins.

In the Chair : Clarence L. Endicott, D.D.S., L.D.S.

Correspondence

DENTAL STUDENTS' CONVENTION.

To the Editor of the Gazette.

SIR,—Mr. Walley, the chairman of the Southern Regional Council, and I would like to thank those students in the London Dental Schools who devoted so much time and worked so hard for the success of the Dental Students' Convention. We feel that the labour was not in vain, for the response which attended our combined efforts was considerable and justified your enthusiasm.

Yours faithfully,

Royal Dental Hospital, W.C.2. D. DOUGLAS DERRICK.

STATE-CONTROLLED HOSPITALS.

To the Editor of the Gazette.

SIR,—We are viewing with alarm and apprehension the attitude of some of the medical staff who are inclined to favour the State control of hospitals, or who, if they do not actually favour it, are letting matters slide without weighing the pros and cons.

We would ask them to get in touch with the Guy's staffs—administrative, medical and nursing—who, for the last four years, have hit their heads in vain against the brick wall of inertia which surrounds those people who administrate from a central office—those people who do not know the needs and requirements of the hospitals under, or partially under, their control.

Do the physicians and surgeons who go round our apparently peaceful Base Hospital wards realise what a treadmill their ward sisters have gone through to make their wards what they are to-day—and they are still far from perfect ? There are many grey hairs in the heads of the Sisters not caused by Anno Domini. We have suffered from inaction, delays, or the total disregard of our essential needs. Those of us who work in county-controlled hospitals as administrators of various departments realise only too well the enormous disadvantages and impediments caused by lack of understanding and personal contact.

We are aware that there should be no waste in spending public money, yet we witness with astonishment the ordering of food and supplies for us by a central office many miles away without the detailed knowledge of our immediate needs.

There is a constant game of battledore and shuttlecock with responsibility and those of us who desire to see progress are left with a sense of frustration and exasperation. We came from Guy's, where everyone, from the Superintendent to the humblest gardener, was a faithful servant, with the interests of the Hospital wrapped up in his heart. We come to places where, owing to immovable regulations, the patient is not considered as an individual with his own special needs and treatments, where courtesy and consideration are replaced by routine and regulation.

Let us look well before we leap into this still water !

Yours, etc.,

Ex SISTER LYDIA.
SISTER NAAMAN.

The Chairman of the *Gazette* Committee is anxious that this letter should be published because of the great and immediate importance of the question ; he is anxious that no offence should be caused and thinks that the friendly personal relations that have now developed between Guy's and the County Councils—members and officials—will prevent any misunderstanding from criticism of the system.

THE GUY'S BRANCH OF THE S.M.A.

To the Editor of the GAZTETE.

SIR,—The Branch was formed rather less than six months ago by a few individual members of the S.M.A. Since then, gradually overcoming the difficulties of organisation, the membership has grown to over thirty and, more important, includes members from nearly every department of the Hospital. With the growth in size of the Branch there has been an increase in the vigour and scope of its activities. These activities include regular weekly discussions on medico-political subjects, general meetings addressed by outside speakers, going on rounds with a factory doctor, and soon a film show will be organised.

The aims of the Branch are, of course, bound up with those of the Socialist Medical Association as a whole. Since its foundation in 1930 the Association has done much valuable work, including the formation of the Spanish Medical Aid Committee in 1936, examination of social conditions in relation to disease, examination of medical organisation in peace and war, and has made recommendations, many of which have been accepted by the appropriate bodies. The membership is well over a thousand, including representatives from all sections of the medical services all over the country. It is being consulted by the M.O.H. on the setting-up of a " comprehensive national health service," it has members on the medical planning commission of the B.M.A., and it advises the left-wing movement on health problems. The chief aim of the Association is to secure for the people the highest possible standard of health by promoting legislation for the purpose, and ultimately by means of a socialised medical service, both preventive and curative, free and open to all.

It is clear that if we are to have any say in the big changes looming ahead, we must know something of the structure of the medical services, how they have developed, how they are likely to develop, and how they fit in with society as a whole. It is in order to study these things, and influence them, that the S.M.A. as a whole—and Guy's Branch in particular—have been formed.

It was with deep regret that we heard of the death of Mr. Lambrinudi. He was the President of the Socialist Society in Tunbridge Wells, our of which the Guy's Branch of the S.M.A. originated. We would like to express our condolences to his wife and family.

E. G. MURPHY, J. F. DUDLEY,
S. F. TIZZARD, A. S. DIXON
(Committee of the Guy's Branch of the S.M.A.).

Several further tributes to Mr. Lambrinudi have been received too late for inclusion in this issue. They will appear in the next.

Reviews

Food and Planning. By J. R. MARRACK. Published by Gollancz & Co. 1942. 285 pp. *Price* 15*s.*

IN recent years it has become increasingly evident that all sciences have a sociological and an economic aspect, which must be fully considered in any extension or application of these sciences. This is obviously true of the science of nutrition, which affects human life so directly; yet most writers on nutrition either treat these relationships superficially or ignore them altogether. Professor Marrack, in this very good book, shows that he is well aware of the economic as well as the scientific side of nutrition.

This book is not a conventional text-book of nutrition, but is written for the layman. It is, however, just as informative as any text-book and is written in a lively and interesting style. The first part of the book deals with food—its composition, nutritive value, requirements, deficiency effects—much experimental evidence being quoted in support of the statements. There is a chapter on the relation of diet to health and one on the distribution of food supplies over the world and food habits in different countries. In the remaining chapters there is given a critical account of the measures used in the last war to control food and, by applying the lessons learned then and modern nutritional knowledge, a scheme for efficient food control in this war is evolved.

This book is recommended to all intelligent people, for whom it should prove stimulating reading. There is, unfortunately, no index. M. L.

"Jacobsoniana"

He wrote exceedingly well; his account of John Hilton is just what a good biography should be. His "Operations of Surgery," published in 1889, was quickly seen to be an exceptional book. It has gone through many editions. When you saw him you felt you were in the presence of a man of distinction and sincerity.

A Guy's man, in practice in a town in Essex, got Mr. Jacobson down to operate on one of his patients. When they were back in the doctor's consulting room afterwards, he asked Pom if he would like to see his children. Pom: "I'd rather see your dogs, sir!"

One afternoon Pom and his house-surgeon went upstairs to see one of his cases. Having done so Pom rushed off, leaving the house-surgeon to do the dressings, but he gave the house-surgeon a cigar before going. Directly he got out of the ward afterwards the house-surgeon lit the cigar and started down the stairs. He heard someone hurrying upstairs and was surprised to find it was Pom returning for something he had forgotten. Pom: "There's a cloud between us." House-surgeon: "I hope it won't be the last, sir"—upon which Pom gave him another cigar.

Sport

Association

1942–43 SEASON.

In their first season with with H.O.P. as the home ground the 1st XI soccer team must have had one of the most successful seasons ever. They played 24 games, won 20, drew 2, and lost 2. They scored 143 goals against 34 scored against them.

Though to some extent the war-time opposition may account for these results, this should not apply to the other hospitals, some of which have been able to give Guy's a close game. The two games against St. Thomas's were the closest and much enjoyed.

The side has played throughout the season as a team, but if any names require special mention they are those of D. Middleton and R. D. Rogers. The former, a centre-half, has been a tower of strength in the defence; and the latter, playing inside forward, has made and scored many goals. The forward line has great powers of scoring as the results show, though the defence say that numerous open goals have been missed; however, the forwards think the defence has been rather shaky when hard pressed.

If there is anything specific to criticise about the side it is that it seems unable to take advantage of its own throw-in. Undoubtedly the biggest factor in the success of the side has been the excellent team spirit, and it is this that has also made the season thoroughly enjoyable for those who have taken part. J. Elder, D. Middleton and C. S. Mathews have played in every game.

The team would like to thank Mr. F. N. Brock, who has refereed the home games, and the secretary, R. Finney.

The chief goal scorers were: R. Finney and J. Elder, 27; R. D. Rogers, 23; E. G. Murphy, 18; C. B. Clarke, 16; and W. R. Hall, 13.

Members of the side have been—N. J. Crane, R. Middleton, N. T. McNeil, F. L. M. Young, D. Middleton, C. S. Mathews, E. G. Murphy, J. Elder (captain), C. B. Clarke, R. D. Rogers, R. Finney and W. R. Hall.

J. ELDER,
Capt., Guy's F.C.

Cricket

Guy's opened the season with a game against Public School Wanderers at Honor Oak Park on Saturday, May 1st. Guy's batted but started badly, 4 wickets being down for 15. C. S. Gardner then appeared and, playing very nice cricket, scored a very typical hard-hit half-century. He was partnered at this stage by G. Thompson, who batted admirably, but was unfortunate in being caught after scoring 45. The innings ended at 146, which was satisfactory after such a poor start.

The weather, which had been dull throughout, now began to deteriorate and Public School Wanderers only had an hour's batting before rain stopped play. In this time they scored 86 for 4 wickets, chiefly due to a quick 53 by P.O. W. D. Ross, the opening batsman. The Guy's bowling lacked practice, the bowlers during the last half-hour being also handicapped by a wet and s ippery ball. The fielding was quite good for the first game, and there is hope that Guy's might in future not give so many runs away as in the past.

Team.—E. W. R. Alderman (captain), C. S. Gardner, G. W. Garland, E. G. Murphy, D. C. Boyd, G. Hildick-Smith, S. G. Beaton, G. Thompson, A. E. Trist, R. D. Rogers, P. C. Matthews.

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF PHYSICIANS.
M.R.C.P.
April, 1943.

K. O. Rawlings W. G. Tillmann

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
April, 1943.

Surgery.—*P. L. G. Cole, *J. S. Pegum.

Pathology, Bacteriology and Forensic Medicine.—*D. M. Carnegie.

Medicine.—*D. M. Carnegie.

* Have completed the examination.

Royal College of Surgeons

F.R.C.S.

Dr. H. I. Shaheen Bey, of the Kasr-el-Aini Hospital, Cairo, has been elected Fellow under the Charter which permits the Council to elect annually to the Fellowship, without examination, two members of the College of twenty years' standing.

Appointments

T. G. Robinson, M.R.C.S., L.R.C.P., M.C.O.G., has been appointed Medical Superintendent of the General Hospital, South Shields.

J. C. Colbeck, M.B. (Lond.), has been appointed Pathologist to the County of Warwickshire.

Maj.-Gen. D. Clewer, C.B. (ret.), has been appointed Colonel Commandant, The Army Dental Corps.

Papers by Guy's Men

Bradley, W. H. Endemiological Study of Bact. Typhosum Type D4. *Brit. Med. J.*, 1943, i, 438.

Craft, A. W. J. The Care and Treatment of Amputations. *Med. Pr.*, 1943, **209**, 186.

Rowlett, A. E. Possible Reactions of the Dental Profession to the Beveridge Plan should it become Law. *Dental Record*, 1943, **63**, 86.

Broster, L. R. Vomiting. *Post-Grad. Med. J.* 1943, **19**, 97.

Hale-White, R. Diarrhœa in Adults : Some causes and their treatment. *Ibid.*, 105.

Change of Address

R. M. Corker, F/Lt. R.A.F.V.R. (81302), A 6900 A.P.O. 5200.

J. E. Giesen, Capt., 2nd N.Z.E.P. (615154), N.Z. A.P.O. 150.

J. B. Good, F/Lt. (62635), R.A.F., India Command.

S. Suzman, Major R.A.M.C. Private address unchanged. 84, Harley Street, W.1.

John Wyeth & Bros., Ltd., Clifton House, Euston Road, London, N.W.1.

Prisoner of War

Sister Nora J. Jones, Changi Camp, Malaya.

Births

CHANNING.—On May 2nd, 1943, at St. Brenda's Nursing Home, Clifton, Bristol, to Kathleen (née Hill), wife of F.O. Geoffrey H. Channing, B.N.A.F.—a son.

JOYCE.—On March 11th, 1943, to Nancie (née Dryden), wife of F/O H. L. Joyce—a son (Michael Richard).

SEDGWICK.—On May 11th, 1943, at Seabourne Nursing Home, West Southbourne, to Molly (née Brent), wife of Capt. D. B. Sedgwick, A. D. Corps.—a son (Julian Douglas).

Marriages

MAYER—DRAGE.—On February 16th, 1943, in the Middle East, J. H. Mayer, Major, R.A.M.C., to Pam Drage, A.T.S.

Deaths

BOX.—On May 2nd, 1943, William Frederick Box, M.B., of Bridge House, Stratford-on-Avon.

DENNY.—On April 23rd, 1943, H. R. H. Denny, C.B., Surg. Rear-Admiral (retd.), of Thorn Park, Mannamead, Plymouth.

GASK.—On April 13th, 1943, Charles Herbert Gask, M.R.C.S., L.R.C.P., of 6, Litchfield Court, N.W.

LAMBRINUDI.—On April 21st, 1943, suddenly, at the Oast Cottage, Mayfield, Constantine Lambrinudi, F.R.C.S., aged fifty-three.

EDS. { J.O.L. / R.R.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE return of more seasonable climatic conditions has been reflected in the sight of patients from the Eye Ward sunning themselves in the Park. The odd attitudes of students, comatose on the grass, is also due to the same phenomenon and to the finish of the M.B. exams., the results of which have just scattered their usual quota of sunshine and showers, if we may be permitted to lapse into the poetic vein. A much less pleasant feature of the last week has been the continued, if unsuccessful, return of enemy aircraft to our skies, with the resulting disturbed nights and spurting of ack-ack fire at intervals, but, so far, no casualties.

Many people have, no doubt, commented on the minor invasions of the Hospital by American officers during the last two weeks. Several courses of one week each have been planned with the idea of showing any American medical officer who is interested, the working of the London hospitals and also some of the "sights of London." They come from all parts of the country and are billeted in town. Facilities have been offered by several hospitals, including the London, St. Mary's, the Middlesex and others. At Guy's an attempt is made to show them the historic side of the place, in particular; and visits are paid to Thomas Guy's tomb, to the Museum and Library, to the Incident Room, and, from the historical motives, of course, to "The George." On the up-to-date side they are shown the new Pathology building and the Out-patients', with its appointment system. We are especially glad to welcome these visitors to Guy's in view of our close association with our friends across the Atlantic, who have so generously contributed gifts, supplies and equipment for our U.S.A. hospital at the Wildernesse.

MEDICO-POLITICAL interest has recently centred on the discussion between a representative committee of the B.M.A. and the Ministry of Health. The main stumbling-block is the intricate and important matter of the system of control of any form of organised medicine. The Government, having temporarily disregarded the profession's proposals for a separate, non-government, corporate body in control, the B.M.A. committee indicated their unwillingness to submit to the stranglehold of local authority. And so it goes on! However, the discussions are on a strictly "non-committal" basis and both the profession and the public will have to be fully informed before any final decisions of action can be taken.

In 1881 a Soccer team was first formed at Guy's. In 1882 a committee, under the auspices of the Rugger Club, or Football club as it was then, was formed to look after its affairs. In 1883 the team obtained a ground of its own to play on, having previously had to use the rugger ground when not otherwise in use. Therefore, the diamond jubilee of the club falls in one of these years, and since we are now in the third and last of them, how about it, Association Football Club? The Rugger Club celebrates its centenary next season, so we feel that the occasion is ripe.

WE are informed that Mr. H. L. Eason, C.B., M.D., late Superintendent of Guy's and now President of the General Medical Council, will be giving a lecture on Friday, June 4th, at 1 p.m., in the Anatomical Theatre. His subject will be "Infamous Conduct in a Professional Respect or What a Doctor may or may not do." We need hardly recommend our readers to go and hear this really "straight from the horse's mouth!"

THAT Air-Commodore Symonds should have been chosen to give the Croonian lecture to the Royal College of Physicians this year is a well-deserved honour, and we trust that many Guy's men will be able to hear it, the more since the exigencies of service make the speaker such an infrequent visitor to the Hospital these days. His subject is "Flying Stress."

A Tribute

CONSTANTINE LAMBRINUDI, F.R.C.S.

ONE of the best tributes to Mr. Lambrinudi's memory is the eagerness that all associated with him have shown to record publicly all that he meant to them. Unfortunately, the lack of space has prevented the publication of these truly spontaneous appreciations in entirety, but if the following gives but some idea of what Mr. Lambrinudi meant to Guy's, readers will be able to draw on their own memories to fill in the gaps.—EDITOR.

Mr. Lambrinudi's influence on those who worked with him ranks high among his many contributions to orthopædic surgery. His ability to infuse his enthusiasm into others, his great generosity in delegating work and his keen interest in the surgical careers of his assistants made working with him a rare experience and a privilege which his pupils will not quickly forget. His energetic approach to an orthopædic problem was a constant sourse of stimulation and inspiration, and he earned for himself a reputation as a brilliant original thinker with bold unorthodox ideas. His opinion on any orthopædic subject was valued highly, especially by the younger generation of orthopædic surgeons to whom his fresh and often unusual views made a special appeal. These lovable and highly personal characteristics will be sorely missed by those of us who had the good fortune to work with him. J. S. B.

It is difficult to express the sense of loss that we all feel here. I can add little in praise of his brilliance as a surgeon, but would like to pay a personal tribute to his qualities as a friend of every member of the Staff, of the Hospital with which he so closely identified himself, of his patients and of myself.

He always enjoyed his work at Pembury and contributed frequently to the social occasions which he regarded as a tremendous factors in the life of the Hospital both for the staff and the patients. He worked untiringly to segregate and modernise the treatment in the Orthopædic Unit, but never wanted his specialty to become detached from those of other workers; he believed firmly in watching and learning from his colleagues in every department and discussing cases with them. His patients were devoted to him and often came back when on leave to report on their progress. Their letters were one of his greatest joys.

He looked forward to the establishment of a permanent centre for orthopædics at Pembury, in which he was encouraged by the support of the Staff and the Kent County Council. To that end he was on the point of moving to a house close to the Hospital in order to obtain more personal contact with the life there. He also hoped within a few weeks to enjoy the new orthopædic unit with his own operating theatre, massage department and wards.

He believed it essential also that all his assistants should take a personal interest and responsibility in treatment and have the security to enable them to do so.

As a personal friend he was one of those rare individuals whose influence seems to reflect both the past and the future. Without ever forcing his advice he nevertheless seemed to form the pivot on which one turned at the critical moments in life. He enjoyed a good argument, a good joke, a good meal and a good drink, but his work always came first and foremost. R. H. B. (Pembury).

There will be many of his colleagues to pay tribute to the eminence of Mr. Lambrinudi in his profession, the high quality of his work, and the inspiration of his ideas and his ideals. Memories that will always delight a member of his firm are of his tremendous infectious enthusiasm, his remarkable vitality, his conscientiousness, and the softness of his heart.

Even when all at Guy's knew that his health demanded that he restrict his operating he could not bear to give up any of his work or suffer his enthusiasm to be tempered with overmuch discretion. Now and again during a rare lull in an out-patient clinic he might vanish, to be discovered lying at full length upon a couch like an effigy on a crusader's tomb, smoking quietly and enjoying, as he said, "complete deliberate relaxation of every muscle, my boy; you should cultivate the art—a wonderful sensation . . . ."

My most vivid recollection of him dates back to the time when I was a dresser attached to the orthopædic firm of which he was Registrar. I was assisting him in an

operation, and he was doing something very deft in the middle of a maze of tendons, when I heard him murmur to himself, "How I *love* operating!"

An intensely humane spirit was the highlight of his character. "Sit down, Sonny," he would say to the old sailor, "and show me how much better you are." The fierce old-timer regimental sergeant-major, with probably a grouse, he would mellow with "How are you, laddie?" At Out-patients', on the afternoon before his death, I saw him remove his shoes and socks and show a soldier exactly how to do the foot exercises. It was small supple feet that he showed, with his toes so well controlled that he could almost write with them. And yet they were the feet of legs that could barely walk thirty yards and he had to stop. They were feet without pulses and, as the femoral pulse in one disappeared several months previously, he said to me: "I'm not worried if my leg has to come off; I am quite sure I'll be able to carry on perfectly well with an artificial leg." . . .

The same day of his death there arrived in the Hospital a middle-aged lady who needed one of Lambri's multiple toe operations. "My son," said she, "is flying in the R.A.F., and you know what that means. He is due on leave in about ten days' time. I would like to be at home then. Can I do this?" "My dear lady," he replied, "go home; you come in when it suits you. We doctors are entirely at your service." She smiled, but he meant every word of it. Lambri was very conscious of our obligations to the poor. He looked forward to the fullest national medical service for them; in fact, it was his frequent boast that he was fully "left" in his views. How pleased he was to see Guy's start the system of out-patients by appointment at night. Once a week he went to Guy's and held a special evening clinic so as to give munition and other workers the opportunity to attend after the day's work. . . .

Of his orthopædic work I hope others will write. Outstanding in this war has been his contribution to the problem of the soldier's foot; his work on backache and sciatica was just beginning to bear fruit; he had planned to write up his studies of knee-joint injuries and had devised a new test for cruciate ligament rupture; at the recent Orthopædic Association meeting his ingenious explanation of the mechanism of scaphoid fracture was enthusiastically received. Incidentally, on the day of his death, he told me that he had not yet written this up for publication; fortunately a *Lancet* annotation published shortly after the meeting fully records his views.

Lambri was a very happy man. But there was one to whom he always paid tribute and I am sure that in anything said of him he would have liked that of his wife, "Aletta," included. Her care and love, he repeatedly told me, and everybody else, enabled him to have achieved what he did. We mourn with her in her grievous loss. His two children will in the years to come be comforted by the memory of a beloved, noble and honoured father.

S. M. C., J. W. S., *et al.*

Correspondence

RE FOUR CASES OF EPILEPSY.

To the Editor of the GAZETTE.

SIR,—Epilepsy, when occurring in any member of the Services, is always a matter of interest. A man cannot be invalided from the Service for this condition unless he has been actually seen in a fit by a medical officer and so certified by him.

It is most important to go fully into the history of each case, especially as regards—(*a*) residence in tropical or semi-tropical countries, and (*b*) whether the epilepsy came on during or after such residence. If so, always syspect cysticercosis as the cause and have X-ray films done of arms, thigh muscles and head. Proof is often dramatic.

Remember that it is not impossible to acquire cysticercosis even in this country.

Such patients always show a normal eosinophile count *unless they have a free parasite in the alimentary canal also*, when it may be raised. Therefore, if raised, look in the stools for eggs also.

Control the fits with luminal and do not attempt treatment with intravenous parasiticides or you will probably kill the patient. The fits often die out after five to seven years with death and calcification of the parasites. But this does not always happen.

I am, etc.,
UNCLE HARRY.

Some Neoplasms of the Maxillæ

By F. N. DOUBLEDAY, L.R.C.P. (Lond.), M.R.C.S., L.D.S. (Eng.).

A Clinical Lecture delivered in the Medical School, Guy's Hospital, on Monday, January 18th, 1943.

GENTLEMEN,—The dental text-books record a large number of neoplasms as occurring in the maxillæ. Comparing this list with that given in Boyd's "Pathology," one sees that many new growths are modified when they occur in the specialised tissues occurring about the jaws. The specialised knowledge of the dental surgeon may be helpful to the doctor in his consideration of such cases. In this lecture it will only be possible to deal with those which are most frequently seen. The fibrous epulis is a tumour which arises from the junction of the periosteum and periodontal membrane of a tooth. When two teeth, with such a growth between them, are removed, the epulis is often found to be adherent to the periodontal membrane, and so to the root, of one of these two teeth. The term comes from the Greek ἐπὶ = upon, τό οὖλον = the gum. It is a fleshly swelling arising between two teeth. In the lectures which he delivered here Salter[1] describes the tumour as pushing up the interdental papilla from beneath, and so it arises, sometimes attaining such size that it becomes bitten upon and ulcerated. It is composed of fibrous tissue, covered with squamous epithelium, beneath which round celled infiltration is seen. The cause is believed to be irritation by the jagged edge of a carious tooth, by toxins, or by deposits of calculus. The treatment consists of excision of the tumour from its base, including the interdental septum between the teeth or, in advanced cases, the tooth from which the tumous is growing.

The myeloid epulis or osteo-clastoma (syn. myeloma) is a tumour similar to those sometimes seen in the ends of the long bones. In the jaws it usually occurs in the mandible and may be periosteal or endosteal in origin; in the long bones it is said to be always endosteal. It is distinguished from a fibroid epulis by being more vascular, darker in colour—maroon coloured—and of softer consistency. It is connected more definitely with the bone and is lobulated. Skiagrams may show that a fibroid epulis is pushing teeth apart, but there is only a little absorption of bone; in the case of an osteo-clastoma the roots of the teeth are undergoing absorption and there is marked absorption of bone, spreading out in large cup-shaped areas. Histologically the tumour consists of masses of fibrous tissue, covered by stratified epithelium. In the substance of the tumour are many blood-vessels and large numbers of multi-nucleated giant cells. Boyd discusses the pathology of the condition in relation to osteitis-fibrosa; he considered that the two conditions are really two stages of one disease, the osteo-clastoma being the rapidly growing and destructive phase and osteitis a healing phase in which the formation of fibrous tissue and bone are the chief features. As they increase in size osteo-clastoma cause great hollowing out of the body of the bone. This may result in neuralgia and pressure symptoms from the inferior alveolar nerve and even in spontaneous fracture of the mandible. The tumours will sometimes disappear after treatment with deep X-rays and this should be tried first. If it fails excision, with thorough curretting to remove osteoclasts which may be adherent to the bone should be performed. The conditions just described must be distinguished from simple hyperplasia of the gum cells. This is a superficial increase in the number of cells along the gum margins resulting in a redundance of the tissue which may be local or general. It is generally due to toxic irritation which is the result of failure to clean the teeth and gums. Overcrowding of the teeth in the dental arch and mouth breathing[2] are important predisposing causes. Sometimes the condition occurs in a symmetrical manner on the palatal aspect of the upper molar teeth, the soft tissue bulging out from either side into the palate. It is thought to be increased by the sucking effect produced as the result of deglutition. The treatment of hyperplasia is to eliminate the predisposing causes and to remove the overgrowth by operation. Osteitis fibrosa is a condition seen in children and young patients; it is an osteo-dystrophy, closely resembling a neoplasm and affecting principally the maxilla. This appears to be uniformly enlarged on one side, producing deformity of the face and sometimes proptosis. On examining the palate it will be found that it is not symmetrical; the affected side is much larger than the other and the alveolar process is bulky. There is a long history; in one of my cases there was evidence of its beginning in infancy and the patient only came for treatment at eighteen years of age. Histologically the mass is seen to consist of a number of cysts, separated by fibrous tissue, which in places

undergoes a poor sort of ossification. Osteoclasts and osteoblasts are very numerous since the condition is one in which bone is continually absorbed and then reformed. The blood-vessels are not very abundant. There are two varieties of osteitis fibrosa; in one which is localised to the jaw there is no rise in the ionic blood calcium, in the other similar changes are seen in the ends of the long bones, it is a generalised condition. In this the ionic blood calcium may be raised. In some cases it has been thought to be associated with enlargement of the parathyroid glands. The treatment of osteitis fibrosa is to operate and remove as much of the swelling as possible; it is fairly soft and shaves off easily, owing to the comparative paucity of blood-vessels hæmorrhage is not a great difficulty; it can be controlled quite well with hot sponges. It is important to keep the wound very clean and free from food infection until it heals. Boyd links osteitis fibrosa with osteo deformans, a rarer condition, seen in older patients. In this disease the bone is first softened and deformed, and then undergoes an intensely compact and massive calcification.

Lastly, it is necessary to describe malignant disease in the mouth, and of this one cannot speak too seriously. Every year at least two or three cases of carcinoma of the mouth are sent up to my dental clinic for diagnosis after the condition has been present for two or three months undiagnosed. On the other hand, one must remember that some patients live in a haunting dread of cancer and that it would be very wrong to disturb them, perhaps without cause. It is proper to be always watchful and observant and, in any doubtful case, to seek a second opinion from those who see these cases more frequently. Carcinoma of the mouth often commences towards the back of the mouth, as an ulcer on the side of the tongue or in the floor of the mouth. A broken and jagged molar tooth is often responsible for it. Some of the text-books say that there is no such thing as carcinoma of a tooth socket. This is a mis-statement founded upon lack of clinical experience. Some of the most tragic cases begin in this way. A dentist removes a tooth and the socket fails to heal. This is attributed to dry socket, a fairly common condition due to absence of blood clot following the injection under pressure of local anæsthetic solutions containing adrenalin. When, however, one looks into these particular sockets with a good light there is a glistening mass of epithelium, like a minute cauliflower. Biopsy shows this to be epithelioma. Unfortunately in such cases operation shows that the growth has got well down into the jaw and surrounding parts and into the glands. The growth in these cases is very rapid. One of the earliest signs is the commencing infiltration of the tongue muscles. This results in some limitation of the power to freely protrude the tongue and it will be noticed that in protrusion it deviates slightly towards the side of the lesion. The part around the ulcer will be hard and infiltrated, the lymphatic glands will be enlarged at first those lying deep to the submaxillary salivary gland, in the digastric triangle and then those along the anterior border of the sterno-mastoid. They tend to be massed together and to be adherent to each other and to the structures superficial and deep to them. As to the treatment of carcinoma of the mouth my experience is that prompt and drastic operation offers by far the best hope of success; next to this of the cases I have seen deep X-ray therapy has been more satisfactory than radium therapy, but neither, so far, has proved so effective as surgery.

REFERENCES.

[1]Salter, J. A. S. "Dental Surgery and Pathology," Longmans, London, 1874.

[2]Lane, W. Arbuthnot. "Appearances," *Guy's Hospital Gazette*, 1907.

Sir Samuel Wilks

The author of the following reminiscences, Miss M. E. Durham, is the daughter of Arthur Durham, Guy's surgeon, and is herself well known to many old Guy's men. She is an authority on the Balkan States, about which she has written several books, and readers will see that time has in no way dimmed her wit.

As my father—Arthur E. Durham, surgeon of Guy's—was constantly operating, he avoided us children when we had an infectious complaint and handed us over to Dr. Wilks, as he then was, who saw us through the measles, chicken-pox, scarlet fever and other complaints which we imported from school. Thus my acquaintance with him dates from very early days. We all looked on him as a friend and I remember shouting, "Whelks and winkles" at him over the nursery banisters. My friendship with him continued and became a deep regard and, when he had retired from practice

and was living at Hampstead with his stepdaughter, I used often to have tea and a chat with him. I would find him studying *The Lancet* or the *British Medical Journal*, deep in the latest discoveries and theories. Some of us on growing old become fossilised and denounce "new fangled" methods. Not so dear old Sammy. He would point out an article in the paper and say: "Oh! If we had only known that fifty years ago!", and would give explanations often too technical for me to follow. After discussing anti-toxins, in which he was deeply interested, he would open a drawer and show me two ivory points that still had dried vaccine on their tips and had belonged to the great discoverer—Jenner.

Talk one day turned upon the question: How far is it the duty of a doctor to risk his life for his patient? "I was brought against this in a very alarming way early in my career," he said, and he told me the following experience:—So soon as he was qualified he obtained the post of second assistant to a doctor in Yorkshire—at Scarborough, I think. The other assistant was an older and an experienced man and to Wilks fell mainly the rolling of pills and making up of prescriptions, doctors then dispensing their own drugs. Only the dullest odd jobs were assigned to Wilks and he sighed for a patient of his own.

His chance came at last. One evening, when the other two men were out, a man dashed up to the door in a dogcart and begged for immediate help. His wife, he said, was in labour—very bad—in a camp out on the moors. Young Wilks was delighted. He seized his bag, leapt into the cart and away they dashed over rough tracks to the heart of the wide moor. The man meanwhile explained that he was a showman, travelling with a lot of wild beasts. His wife was expecting her first child and he had arranged that she was to go into lodgings and had engaged a doctor. They were going there by slow stages, giving shows *en route*, when she had been seized with pains a whole month earlier than had been expected, and was so bad that he feared to carry her further and had pitched camp and come for help.

Wilks found his patient in a small tent miles from anywhere and surrounded by wild beast cages. He saw at once that his task was a serious one. The child was in about as bad a position as possible and the woman already dangerously exhausted. Save the stable-boys and the half-distracted husband there was no one to help him. He feared he would lose either mother or child—perhaps both, but he pulled himself together, tried to remember all he had learned on the subject and set to work. It should be remembered that in those days there were neither antiseptics nor anæsthetics. Finally, after some anxious hours, in the grey of the morning, to his joy he delivered a live child and the mother, though very weak, was in a by no means hopeless state. Said Sir Sammy to me reflectively: "I don't think I was ever more pleased about a patient than I was then!" The showman, who had lit a fire on the ground, supplied hot water and made tea, while Wilks washed and dressed the baby and attended to the woman. All three drank tea and, all being well, Wilks was driven home. He spent much of the morning buying what he thought suitable invalid food and hastened with it in the afternoon.

All went well. The patient made a perfect recovery with no complications; in fact, she probably did better in the pure moorland air than had her confinement taken place in small town lodgings. When at last there was no need of a further visit from the doctor and the menagerie was being made ready to move on, the showman said: "My wife and I don't know how to thank you. We've talked it over and want to give you a real treat. So we are going to let you see the boa constrictor feed, for nothing. It is an extra in the show." So saying, the showman turned to a big chest which had been standing all the time in the patient's tent, threw open the lid and dragged out an immense boa constrictor which he threw down before the astonished Wilks, saying: "Keep an eye on him, doctor, while I fetch a rabbit." The boa, which had been fasting a week or two, was extremely lively. Said Wilks: "It began rushing round and round the tent, darting its head about. The woman sat quite calmly with the baby on her knees. Then I saw the boa fix its gaze on the infant. The cold sweat ran down my back. Was it my duty to stop the brute? Should a doctor save his patient from the boa constrictors. It got nearer and nearer. Just as I was about to dash between it and the baby, the showman reappeared and flung down a rabbit. The serpent pounced at once. The situation was saved. I was never more relieved in my life!" Then he added: "But it did not settle the question: "How far is it a doctor's duty to sacrifice himself for his patient."

To the last he was keenly interested in medicine and the teaching of it. He would say: "There is no mystery about medicine. It is a matter of intense observation,

and a lot of commonsense and patience. Any fool can learn materia medica by heart. So many grains for an adult; so and so many for a child, but the point is: how will that dose act on that particular patient? That is what needs all your powers of observation. When you go round a ward you would be surprised if all the patients had the same faces. They are not the same outside. Don't imagine they are all the same inside. No two patients are alike. Don't forget that. Each is a separate problem and it is your business to solve it." It used to be said of him at Guy's that he would enter his ward unexpectedly, walk round, look hard at some of the patients and go away without speaking to anyone.

Again he would say: "Do not forget Nature's immense recuperative power. Never worry or fatigue a patient. Some nurses do too much straightening bedclothes, patting pillows, washing and so on. Won't let the patient rest. The object of nursing should be to relieve the patient of all strain and fatigue. Let him lie as best suits him. Do not wake him up. Let him use all the vitality he has in getting well."

Of his eminence as a physician in his own day there can be no doubt. And I do not doubt that he would have been equally great at any time. And, as are all really great men, he was very modest. "There is still so much to learn," he would say.

My father was fond of giving an example of Wilks's modesty and at the same time of his sense of humour. An international Medical congress took place. Guy's dined the American delegation. Enlivened by Guy's hospitality, the guests began to vie with one another in relating amazing cures. This one, called in to an apparently moribund patient, had treated him by a method never before attempted and promptly restored him to life. Another, under similar circumstances, had performed for the first time an operation none had dared do before, with perfect success. And so on, until one of the guests, thinking they were absorbing too much of the conversation, turned to the chairman and said: "I am sure that Sir Samuel Wilks can tell us of a case in which he saved life by unusual means." "Yes," said dear old Sammy, "when I was young I once jumped into the Serpentine and fished out a woman who had been upset from a boat." I can imagine how his eyes twinkled as he made the remark.

As I near the end of a long life and look back on the many people I have known in many lands, I am proud to have been able to number Sir Sammy among my friends.

Sport

RUGBY SEASON, 1942–43.

As in the past Mr. Roy Holloway, an honorary life member of the Clubs' Union, has compiled the statistics for the past season which are published herewith, and for which we thank him. He has taken a great interest in the Tunbridge Wells XV, for whom he refereed most of their matches.

The published figures show that the averages have kept even with the other war seasons, but one would like to see a reduction in the number of games lost if we are to play a prominent part in the re-organisation after the War when all the big clubs return.

Once again the Hospitals Cup was left in abeyance, but the seven-a-side competition has proved very popular. Middlesex Hospital beat us in the semi-final, but the eventual winners were Mary's. In the Middlesex County sevens Middlesex Hospital beat us again when we went out in the sixth round.

T. L. T. Lewis was acclaimed one of the best full-backs playing, and was included in Thorneloe's XV against Barbarians. A. B. Lee was invited, but examinations prevented him from playing. M. R. Mullins captained United Hospitals against The Army, and other Guy's representatives were D. M. Strathie, A. B. Lee and A. G. Albers. M. R. Mullins also captained London against the Army and D. M. Strathie and A. B. Lee were honoured with places.

C. Vidot and B. H. Wilshere missed only one match and it is rather a coincidence that the Macrae-Gibson brothers, A. C. and N. K., played in eighteen games each and were top try scorers with 10 each.

The three-quarter line gave Strathie a lot of trouble. He himself did not quite recover from injuries received early in the season, but his presence and skill was always a stimulant to the side he captained so well. An unfortunate series of injuries and illness compelled P. L. Brangwin, whom we know to be a class centre to retire completely. D. M. Strathie took his position and introduced N. K. Macrae-Gibson to partner his brother A. C. on the right wing, and their scoring power is shown in the figures mentioned above. J. B. Kyle's injury early on caused trouble on the left wing and, following D. R. Edwards, the position was given to J. N. Micklem, who would have done even better had he kept his speed, swerve and weave going on facing an opponent and made more use of the cross-kick.

The halves, W. H. Lillywhite at stand-off, played consistently well and had a good understanding with R. D. Willcock, but as deputy scrum-half R. N. H. Vann played some extremely good games. The pack was fast in the loose and solid in the set scrummages. A. B. Lee improved his hooking a lot as compared with last season, and he had two good forwards in B. H. Wilshere on his left, and R. G. L. Brittain on his right to form a well-balanced front row. A. G. Albers and A. Batty Shaw in the second row, and C. Vidot in the middle of the back formed a triangle which bound firmly. Of the wing forwards P. D. Harvey was the find of the season, fast, always up with the ball which brought him 8 tries with absurd ease, but the biggest loss of all was the departure of M. R. Mullins to South Africa after

scoring 2 tries, converting 15 tries and kicking 4 penalty goals in 13 games. Much could be written on his short rugger career at Guy's especially as he built his team entirely from the material at the Hospital and Tunbridge Wells without relying on the ready-made from the 'Varsities or elsewhere. Every man had to earn his place and this is the foundation on which the present XV is built. To fill his place D. L. Gullick was included, and nobody more thoroughly deserved the half-blue awarded him, as he was responsible for most of the hard-work entailed in keeping the "A" XV together during the past three years. S. M. Hilton rendered good service and so did D. C. Boyd in the centre.

Thirty-four players have taken parts in 1st XV matches, as follows:—Vidot and Wilshere, 24; Lee and Albers, 23; Lillywhite, 22; Lewis, 20; Harvey, 19; A. C. Macrae-Gibson, N. K. Macrae-Gibson and Brittain, 18; Strathie and Batty Shaw, 17; Willcock, 15; Micklem, 14; Mullins and Brangwin, 13; Vann, 10; Gullick, 9; Hilton, 8; Boyd and Edwards, 7; Kinder and Swann, 5; Kyle, Carruthers, Harris and Hilliam, 4; Long, Hildick-Smith, Ziervogel, 2; Garland, Couper Dalton and Ebsworth, 1.

The following have scored tries:—A. C. Macrae-Gibson and N. K. Macrae-Gibson, 10; Harvey, 8; Brangwin, Wilshere, Edwards, Micklem, Lee and Swann, 3; Lewis, Kyle, Long, Strathie, Mullins, and Vidot, 2; Batty Shaw, Albers, Hildick-Smith, Lillywhite, and Brittain, 1 each.

The following have scored goals:—

	Tries Converted.	Penalty Goals.	Dropped Goals.
Mullins	15	4	–
Lewis	12	5	–
Wilshere	–	2	–
Ebsworth ..	–	–	1
Gullick	1	–	–

making a total of 53 tries, 28 tries converted, 11 penalty goals, 1 dropped goal. Total points, 282.

Our opponents' score was as follows:—37 tries, 12 tries converted, 8 penalty goals, 3 dropped goals. Total points, 171.

Completed figures:—Played, 25; won, 14; lost, 11; drawn, 0. Points for, 282; points against, 171. Average points per game, 11.28 for and 6.84 against. Percentage 56.00.

SEASON 1942–43.—99TH SEASON.

Played	Won	Drawn	Lost	Total Points (for)	Total Points (against)	Percentage
25	14	0	11	282	171	56.00

Opponents.	Date.	Ground.	Result. F	Result. A	For G'ls	For T	Against G'ls	Against T
	1942.							
Middlesex Hospital	Sept. 26	H	16	0	2	2	–	–
London Hospital	Oct. 3	H	22	3	2	4	1*	–
King's College Hospital ..	Oct. 10	H	24	11	3	3	1	2
Royal New Zealand Air Force ..	Oct. 17	H	–	11	–	–	1	2
Royal Navy, Portsmouth ..	Oct. 24	H	11	3	1	2	–	1
Oxford University	Oct. 31	A	10	0	2	–	–	–
Wasps	Nov. 7	A	9	12	3***	–	1*	3
St. Mary's Hospital	Nov. 14	A	3	7	..	1	1†	1
Metropolitan Police	Nov. 21	H	11	16	2*	1	3*	1
Aldershot Services	Nov. 28	A	18	0	2**	4	–	–
Rosslyn Park	Dec. 5	A	6	23	1*	1	5*	–
St. Bartholomew's Hospital ..	Dec. 12	H	8	3	1	1	1*	–
R.N. Eng. Coll., Devonport ..	Dec. 19	H	11	3	1	2	–	1
	1943.							
Royal Navy, Portsmouth ..	Jan. 16	A	3	6	1*	–	–	1
Cambridge University	Jan. 23	A	13	6	2	1	–	2
Royal N.Z. Air Force	Jan. 30	A	23	0	4	1	–	–
Eastern Command	Feb. 6	H	21	8	3	2	1	1
H.M.S. Dædalus	Feb. 13	H	23	3	1	6	1*	–
Metropolitan Police	Feb. 20	H	0	5	–	–	1	–
Aldershot Services	Feb. 27	H	19	3	3*	2	–	1
St. Mary's Hospital	Mar. 6	H	0	11	–	–	1	2
Bedford	Mar. 13	A	4	9	1†	–	1*	2
London District	Mar. 20	H	13	3	2	1	–	1
Wasps	Mar. 27	H	3	13	–	1	3	–
Rosslyn Park	Apr. 3	H	11	12	3**	–	1*	3

* Penalty goal. † Dropped goal.

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF PHYSICIANS.
M.R.C.P.
April, 1943.
J. L. Bates.

Birth

PAGET-DAVIS.—On May 11th, 1943, at Farnborough Hospital Maternity Wing, to Lilian (née Vaughan, wife of D. Paget Davis, Lieut., R.A.M.C.—a son (Paul).

Marriage

SIGGERS—SERRAILLIER.—On March 6th, at All Saints' Church, Maidstone, Ft.-Lieut. R. G. Siggers, of Maidstone, to Rosemary Serraillier, of Ealing.

Deaths

PEMBERTON.—On April 26th, 1943, at Trumpington Hall, Cambridge, William Warburton Pemberton, M.B., B.Ch.

TICEHURST.—On May 18th, 1943, at 54, London Road, St. Leonards-on-Sea, Gerald Augustus Ticehurst, M.A., M.B., B.Ch. (Camb.), aged sixty-four.

EDS. { J.O.L. R.R.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

A MEMORANDUM is published this week summarising the evidence to be offered by the B.M.A. committee to the Interdepartmental Committee on Medical Schools. The B.M.A. committee was a comprehensive one, including specialists, general practitioners, and a representative of the B.M.S.A., and it is therefore of no little interest for all of us to study its proposals. We cannot deal with it all here and everyone should read the report in full, but a few matters stand out in contrast to the general run of things at present. The appointment and status of the teaching staff is reviewed, and it is concluded that, firstly, teachers should be appointed as such, with due regard to their capabilities in instructing others, as well as other factors; and, secondly, to ensure that this principle is carried out, that such appointments should be made by a university board, from an open field of candidates, not solely from the hospital itself. And once such teachers have been appointed they should have their own beds and be in sole and complete charge of their patients, this to apply to whatever hospital the beds are in, either the main teaching one, or subsidiary smaller ones.

Further suggestions deal with the suitability of the present training for general practitioners and the possibility of increasing the emphasis on topics of particular interest to this large majority of the profession. In this connection the committee hope that in future, in whatever form general practice may emerge from the re-organisation in prospect, the general practitioner will be placed in more intimate contact with the teaching hospital, and may be able to give some of the instruction at present lacking.

Finally, as regards the undergraduate student, the question of compulsory house appointments before full registration is discussed. Two views are put forward. One is that the final year of the present five should be spent as unqualified houseman, the curriculum being altered to permit this. The other is the usual one that one year should be spent in such a job after the final exams. and preliminary registration, the complete registration depending on the satisfactory performance of duties during this time. The committee emphasise that there should be no further examination after this, *such tending to nullify the whole principle. The latter idea finds most support* and seems on the whole to have the most chance of acceptance, but if it is to work one point must not be ignored, in fact deserves more emphasis than the memorandum gives it—namely, the salary of the house officer. If he is made to do a year as such, then the question of pay is even more important than in the past when the jobs were, in theory at least, optional. Before the War the pay was non-existent or, at the most, pocket-money. Therefore the newly-qualified man had either to expend his own money as well as his time in order to do a job or go without. Since the man with little money had probably already had a hard struggle to get through the five years previous this system naturally put a premium on money, not brains, as the requisite for a house job, and more progress might have come out of a better system. And another disadvantage of this system, one which is, in fact, still with us, is that there is no provision made for the care of the health of the house officer. He has no definite time off, neither days off in a week or holidays in the year. And although few house officers, perhaps, are ultimately the worse for this, it is more by luck than judgment, and in the long run the hospital probably loses by the shorter periods of illness which are particularly liable to overtake anyone under these conditions. The pre-war state, and status, of house officers, was but an example of what we must avoid; at present, under the E.M.S., the pay is better even in the teaching hospitals, though still lower there than elsewhere, but in other respects we must still seek improvement.

THE honour of knighthood bestowed on Sir Herbert Eason in the Brithday List must be warmly welcomed in the Hospital as the just reward of one who, first at the Hospital and later in the University of London and now with the General Medical Council, has always given of his best and done a job we can all be proud of.

"The Frenzy"

A Clinical Lecture delivered by Dr. Simon Behrman on March 1st, 1943.

GENTLEMEN,—I am using the word "frenzy" in its original designation—viz. mental derangement, temporary insanity. Frenzy, as also the word "frantic," is derived from phrenitis, a word which remained in current use for almost two thousand years. Aristotle, like the modern crooner, believed that the heart and region immediately around the heart were the seat of all psychic functions. Now, the midriff is *phrenos* in Greek, and the word came also to mean "the mind," as a result of these physiological doctrines. Hence "phrenitis"—a disturbed mind. Since, on the one hand, *phrenos* stood for midriff and, on the other hand, for mind, you have such words in modern medicine as "phrenic nerve," "schizophrenia," "hebephrenia," "bradyphrenia," "phrenology," etc. "Phrenitis," since Galenic times, has been used to describe confusional mental states. For the purpose of this lecture, I therefore propose to use the English equivalent of this word—"frenzy," in its original sense. I could not better illustrate the complexity of the subject than by considering in the first instance alcohol as a cause of frenzy. To begin with, there is the immediate and direct effect of alcohol on the brain, the resulting disturbance being directly related to the concentration of alcohol in the blood stream. Thus, when the concentration is 100–200 mgms. per cent., speech becomes rapid and voluble, disconnected and confused; muscular movements more active and unrestrained. The alteration of mood largely depends on the make-up of the subject, some becoming gay and exalted, affectionate, lachrymose, confidential, others bellicose, boisterous, depressed, sleepy, quiet. When the concentration is 300 mgms. per cent., hallucinations and delusions appear; diplopia, tinnitus and some deafness resulting in loudness of speech also occur at this stage. Speech becomes slurred, thick and incoherent. Gait becomes staggering and the subject reels from side to side. Other movements also become ataxic. Stupor supervenes when the concentration reaches 400 mgms. per cent. and apathy and inertia are conspicuous. At 500 mgms. per cent. the "dead-drunk" stage is reached; breathing is slow and stertorous, reflexes weakened or abolished. There is either acute retention or incontinence and death results when the concentration is 600–1000 mgms. per cent.

In complete contradistinction to this acute alcoholic intoxication is the "shaky madness," or delirium tremens. In the eighteenth century it was recognised among sailors who drank heavily between voyages and it was known as "the horrors." From all accounts it would appear that the syndrome has remained unchanged throughout the years and it is as much a mystery now as ever. For a few days before the recognised features of this disease make their appearance, prodromal symptoms cause much discomfort and distress. The patient becomes restless, sleep is fitful and marred by nightmares; he makes an attempt to overcome his distaste for food, the nausea and also a sense of tension which develops, by means of more and yet more drinking. Within a few days the full-blown syndrome develops. In a recent paper Boyd and Rossman have recorded that an abrupt rise in temperature of 1–2 degrees is a constant prelude to the appearance of the full-blown syndrome. Within twenty-four hours the temperature is normal again. In his neurological lectures, which Samuel Wilks gave here some eighty years ago and which have since become classic, he gives a vivid account of this stage. . . . "When you are called to see him in the attack you usually recognise at once the nature of the case; he is probably up and dressed; he may, indeed, be attempting to conduct his usual business; in fact, he generally has a great desire to be about his accustomed avocations; he is constantly moving and wanting to go somewhere or do something, which his friends are as constantly desirous of preventing. As you speak to him he is sufficiently intelligent to know you and sit down for a moment and converse, but it is only for a moment. His restlessness prevents him remaining quiet, and his mind then rambles on all kinds of subjects. If you place him in bed he constantly jumps up, and is suspicious of those around him, or fancies that he sees objects in the corners of the room; if the bed is surrounded by a screen, then he perceives imaginary cats and dogs on the bedclothes, and will attempt to stroke them, or sees creeping things like spiders; or he stretches out of bed to look beneath it, fearing there are persons hidden there. All this time he is constantly fidgeting his hands and perpetually jumping up and lying down again; he is bathed in perspiration, but the temperature is not raised."

In favourable cases, after 3–4 days of uninterrupted delirium, the patient recovers his mental clarity, usually after a long, deep sleep.

Though nothing is definitely known as to the pathology of delirium tremens it is possible, nevertheless, to exclude certain causes. It is not due to withdrawal of alcohol or sudden abstinence. Among 63,000 inebriates who were imprisoned and suddenly deprived of alcohol, less than ½ per cent. developed delirium tremens. Equally certainly it does not appear to be due to vitamin B deficiency. In a recent experiment an alcoholic patient was placed on a regimen consisting of vitamin B_1, nicotinic acid in large doses and a quart of whisky a day. Appropriately enough, he developed delirium tremens on the thirteenth day of this strictly scientific carousal.

Now to turn to yet another clinical manifestation of prolonged alcoholism. Wernicke described focal petechial lesions, symmetrically distributed and confined to the walls of the third ventricle, the grey matter around the aqueduct of Sylvius and the grey matter of the floor of the third and fourth ventricles. This curious selective distribution of the vascular lesions has been confirmed again and again. Since the hæmorrhages were confined to the grey matter, Wernicke thought that the affection was in some way related to poliomyelitis and he called it acute hæmorrhagic polioencephalitis. In view of the strict delimitation of the vascular lesions in these cases, it is only to be expected that the focal neurological signs will be fairly constant from case to case. Various forms of external and internal ophthalmoplegia are the most constant physical signs.

Korsakow, in 1890, drew attention to the occurrence of "cerebropathia," as he called it, or shall we say frenzy, among patients suffering from alcoholic polyneuritis. Soon afterward, the occurrence of Wernicke's hæmorrhagic polioencephalitis, and also of Korsakow's psychosis among patients suffering from hyperemesis gravidarum was recognised, but the connecting link between them was not discovered until recently. It is now believed that both conditions are due to vitamin B_1 deficiency. Of course, clinically, the two conditions—Wernicke's encephalitis and the Korsakow syndrome—often co-exist.

The point I want to make is that alcohol, a comparatively simple chemical substance, is capable of giving rise to confusional states in a variety of ways.

What, then, are the clinical features of "frenzy"? It is difficult to draw a comprehensive enough picture which would include all cases, for the range extends from slight obfuscation of intelligence and memory to the low rumbling delirium seen in severe cases.

Here are some of the common mental symptoms; not all of them, however, may be present at the same time:—(1) Defect of memory, especially for recent events. Though this may be very obvious in some cases, it may be difficult to discover in others. I recently saw one such patient—a journalist, well known for her reputation as a wit and brilliant *raconteur*. When I tried to test her memory her answers were vague and she volunteered very little. If asked something beyond her powers to answer, there was a certain degree of evasion or a little good-natured wise-cracking, so that at times it was difficult to tell whether her reticence was deliberate and prompted by a desire for privacy, or whether it was due to her inability to answer questions at all. Some patients may become angry; others will confabulate. "Confabulation"—a term applied to a tendency to recall events which have never happened—is an extremely variable feature in these cases; it may be very conspicuous in some cases and absent in others. Whether it merely represents a compensation for the defect in memory—a fabrication of memories in an attempt at filling out gaps—or whether it is produced by some other mechanism is still a vexed question.

(2) Defective orientation in space and time. In his powers of orientation the patient is somewhat handicapped by a tendency for sensory perceptions to become readily distorted, so as to make them fit some given situation. Thus, if the hospital is identified in the patient's mind with a hotel or lodgings, the doctors and nurses are misidentified accordingly; they become waiters, waitresses, old drinking companions, etc. It is possibly this defect which is responsible for the increased suggestibility which is usually present to a less or greater extent in these patients. Occasionally patients may be induced to read from a blank sheet of paper.

(3) There is difficulty in switching over from subject to subject; sometimes the patient seems to cling to words just spoken or actions just performed and these are repeated in response to different questions and requests. This is known as perseveration.

(4) Emotional instability results in apprehension, anxiety, irritability, mistrust and suspicion. This may lead occasionally to a false diagnosis of hysteria and psychoneurosis.

(5) Attention is poorly sustained. There is slowness of responses and a tendency to fatigue quickly.

(6) Hallucinations, usually of visual and auditory type, are, of course, common, but they may also be of tactile nature, or they may give rise to a vivid sensation of movement through space. One of Samuel Wilk's patients gave the following graphic account of the sensations experienced in a delirium :—" Hideous faces appeared on the walls and on the ceiling ; foul things crept about the bedclothes ; and glaring eyes peered into mine. And then the scene would change. I was falling, falling, swiftly as an arrow, far down into some terrible abyss ; and so like reality was it that, as I fell, I could see the rocky sides of the horrible shaft, where fiend-like forms were perched, and I could feel the air rushing past me, making my hair stream out by the force of the unwholesome blast." . . .

The mental changes I have just outlined are those most commonly seen in " frenzy" caused by physical disease. These symptoms are usually regarded as constituting the organic confusional syndrome. They must be viewed as indicative of a certain phase of psychic disintegration. This disintegration of personality lends to regression to a lower level of behaviour and to inferior modes of adaptation to reality. There are other abnormal types of reaction to reality, such as have been grouped under the schizophrenic and manic-depressive syndromes. These, too, may be encountered in insanities occasioned by physical disease, though the factors determining which reaction type prevails in any given case remain obscure. It follows, therefore, that in certain cases a differential diagnosis purporting to draw hard-and-fast distinctions between these ill-defined syndromes may be neither profitable nor possible. The first practical and pertinent question should be : " What is the pathogenic agent " ?—notwithstanding that the question cannot be answered in every case. Incidentally, it was because I wanted a word which would not only embrace all these abnormal reaction types, but also the psychoneuroses, that I am using the word " frenzy," which, at any rate, to the present generation, has no definite nosological significance.

Let us now consider some of the physical features shown by these patients—tremor, fine or coarse, thick speech, extensor plantar responses on one or both sides ; also fits, dysphasia, somnolence, cerebellar dysfunction, diplopia, incontinence and, above all restlessness are often present. There is an " absent-minded " grasping of any object which is proffered or placed near the patient, such as fingers or hand of the examiner, or bed-clothes. This has been variously described as " grasp-reflex " and " carphology." Celsus attached considerable importance to this sign ; he says, " It is a deadly symptom, in cases of madness, to gather the wool off the clothes with the hands." With regard to picking and rubbing of the nose, so common in these patients, the following is a statement which appears in a well-known text-book of medicine : " The patients suffering from intracranial tumour have been noticed to rub their noses with such frequency as to render this circumstance a sign of real diagnostic value." Now this diagnostic implication is manifestly untrue, as anyone seeing many cases of delirium of various causation can testify. The prominence of the grasping movement, as well as of the rubbing movement of the face in these cases, must be regarded as " release " phenomena, since the movements appear only when a certain degree of dissolution of cerebral function has occurred, and they disappear again when, as a result of further disease, brain function is disturbed to a still greater extent.

FRENZY DUE TO ANOXIA AND HYPOGLYCÆMIA.

By means of an electric encephalograph it is possible to show that the cerebral cortex becomes electrically inactive after an anoxia of 14–15 seconds' duration. In view of this exquisite sensitivity of the brain cortex to oxygen lack, it is only to be expected that serious cerebral disturbances would follow want of oxygen. Anoxia of the brain can be produced in a number of different ways. Among the earliest investigators in this field was Astley Cooper, who published in the first volume of Guy's Reports a paper relating to the occurrence of fits after the carotid and the vertebral arteries had been tied in rabbits and dogs. Anoxæmia, produced in a variety of different ways is, of course, clinically the most important cause of generalised anoxia of the brain. Little of importance has been added to the subject since J. S. Haldane's study of it. This is what he writes : " If pure anoxæmia is produced very suddenly, as by breathing pure nitrogen, loss of consciousness occurs quite suddenly and with no

previous warning symptoms. If the anoxæmia is produced with only moderate rapidity there is no preliminary discomfort and for this reason the onset of pure anoxæmia is very insiduous and therefore, in practice, very dangerous, as is well seen in CO poisoning, or in ascent to very high altitudes in balloons or aeroplanes, or in many clinical cases. As the slow onset of anoxæmia advances, the senses and intellect become dulled without the person being aware of it and, if the anoxæmia is suddenly relieved by means of oxygen or ordinary air, the corresponding sudden increase in powers of vision and hearing is an intense surprise. The power of memory is affected early and is finally almost annulled. Powers of sane judgment are much impaired and anoxæmic persons become subject, more or less, to irrational, fixed ideas and to uncontrolled emotional outbursts. Muscular co-ordination is affected, so that a man cannot walk straight or write easily. In may respects the symptoms of anoxæmia resemble those of drunkenness. Without reason the patient may begin to laugh, shout, sing, burst into tears, or become dangerously violent. He is, however, always quite confident himself that he is perfectly sane and reasonable."

Severe anæmia, cardiac failure, pneumonia, CO poisoning are a few of the important conditions which, by causing anoxia, may give rise to "frenzy."

Unlike other cells the brain cell derives the energy for sustaining its activities almost entirely from carbohydrate. It is, therefore, not surprising that the effect of a reduction of blood sugar falls, in the early stages, entirely on the central nervous system. The clinical picture of hypoglycæmia is in many ways analogous to that of anoxia, the symptoms ranging from frenzy to fits. Recently numerous cases of hypoglycæmia have been reported following protamine insulin. Because of the slow liberation of active insulin from the depot of protamine-zinc-insulin, there is a temptation to give too much, with the result that hypoglycæmia occurs at night, frequently just before breakfast. Prolonged hypoglycæmia, like prolonged anoxia, may lead to irreversible changes in the brain and permanent damage. This fact must be borne in mind when rapid recovery does not take place following administration of sugar. Only too often this failure to recover is attributed to therapeutic hyperglycæmia and, with a view to checking this, insulin is given.

FRENZY FEVER.

A few ancient authors actually restricted the term "phrenitis" to "frenzie-fever." Thus Barrough, in the sixteenth century, wrote: "Phrenitis is a disease wherein the mind is hurt, and doth only differ from madnesse, which is called in Greeke and Latine melancholia or mania, for that fever is joyned with the frenzie." By far the commonest type of frenzy is, of course, frenzy-fever—*i.e.*, frenzy associated with some pyrexial illness, usually of infective nature. However, pyrexia alone, unassociated with any infection or toxæmia—provided the rise in temperature is high enough—will give rise to delirium. I have seen it constantly among patients undergoing treatment with artificial pyrexia and recently attempts have been made to correlate the patient's reactions to pyrotherapy with an evaluation of his personality made prior to the treatment.

Sun-stroke or heat-stroke are so constantly associated with a delirium that any obscure frenzy occurring in the summer months, even in these temperate climes, is nowadays often imputed to the sun—a renunciation, by the way, of the old doctrine which assigned all forms of lunacy to the moon. Sun-stroke, or heat-stroke, can only occur when the rate of heat production exceeds the rate at which the body heat is lost. Gross muscular activity may double or treble the production of heat, and will, therefore, facilitate the onset of heat-stroke. On the other hand, diminished sweating, brought on by atropine and dehydration, or the high humidity of the atmosphere, are factors which will tend to reduce loss of heat. But the overriding single cause of heat-stroke is high atmospheric temperature—a pre-requisite rarely fulfilled when this diagnosis is made. I am not considering at the moment the direct effect of actinic rays on the pallid skin of our sun-worshippers, though this, too, like any other extensive burn, may be associated with frenzy.

So complex is the genesis and so multifarious are the causes of frenzy that I find it difficult to present the subject in a systematic fashion or to offer any classification which would be of clinical value. One is, therefore, reduced to an at random presentation of the subject, with the resulting risk of incurring the strictures of the nosologist.

CHEMICAL POISONS.

Because of their number it would be a laborious and time-consuming task to catalogue all the poisons capable of causing frenzy. Here are some of the more familiar ones—plumbism, mercurialism, carbon-monoxide, cocaine, morphine, belladonna, hyoscyamus.

Bromides.—Briefly, it can be said that, for reasons which are as yet not definitely known, some people show an intolerance to bromide administration in ordinary therapeutic doses. According to the degree of this intolerance, symptoms and signs of bromide intoxication appear within a few days, weeks or months after such administration was commenced and they gradually increase in severity. The clinical feature of bromide intoxication is that of a confusional state which does not differ in any particular from that described already.

I should like to emphasize that the skin eruptions (acne, erythema, etc.) usually regarded as a feature of bromism are by no means essential features of bromide intoxication. The following is a case of bromide intoxication we had recently in Bright Ward. She was sent up to Out-patients' by her doctor, who wrote : " . . . This patient has been under my care for the past year, complaining of headaches. The headaches, I thought, were due to migraine. She has been having Pot. Brom. gr X, tr. Gelsemi m V t.d.s. She now complains of forgetfulness and inability to concentrate." . . . The patient was vague and incoherent and complained of " nerves and bad headaches." Her husband said : " She is muddly ; calls things in reverse—says " upstairs " instead of " downstairs," " coffee," instead of " tea " ; appears to worry a lot. Bad at shopping—can't remember to take her change ; has had visions during the last month—she could see a strange man in the room ; once she said a cat brushed past her ; forgets things ; can't keep still." Three weeks after bromide was discontinued the patient was able to give a satisfactory account of herself. After commencing her doctor's treatment she became tired ; became nervy and easily annoyed ; could not bear noises ; thought her husband was having an affair with a woman. She heard voices telling her she was going off her head ; could see strange people walk across the room ; had a feeling a lot of worms were crawling about inside her head ; her head felt hollow. Shortly after she was discharged I received a letter from her, saying : " My brain appears to be normal. My memory and concentration quite good ; all numbness has disappeared. I have gained weight. I manage to carry out all household duties again." The particular danger in failing to recognise the occurrence of bromide intoxication lies in the fact that it tends to run a progressive course as long as bromide administration is continued and may lead ultimately to coma and death. There is also the risk that the restlessness, which is such a common feature in these cases, may lead to an augmentation of dose of the bromide already being given the patient.

Methyl Chloride.—In the summer of 1939 a man staggered into the neurological out-patients'. He complained of " feeling very slack " and, beyond this, could give only little information about himself. He was living in lodgings on his own and had no friends in London. He was brought to hospital by one of his mates, like the patient a refrigerator engineer, whose job it was to visit and repair refrigerator plants which had broken down. In voice thick and slurred the patient complained of an appalling taste in his mouth ; " don't feel like work." He related that during the past four weeks weird things had been happening to him. He found himself talking to a hat on a hat-stand, or a mackintosh hanging on a peg. It was a shock to him to discover, after some minutes' discoursing, that there was nobody about. He had curious visions. " A big black pedestal would suddenly appear from nowhere." " Bits of carpet would suddenly stand up." He complained of feeling " kind of inanimate ; you don't know what you are doing ; leaving the work in the air." Some weeks before he had visited his wife in Oxford, but though she was staying only a few minutes' walk from the station and he had known the town well, he spent four hours of the night in roaming about to find his destination. He was inclined to attribute this to a continuous feeling which he had been experiencing for some time of always walking and driving downhill. Examination merely revealed a slight tremor of his hands and a fine nystagmus ; he was walking with his legs wide apart and was inclined to lurch to one side or the other. As already mentioned, his speech was slurred and thick. On direct questioning he admitted to handling methyl chloride continuously in the course of his job. I concluded that his mental and neurological symptoms and signs were due to methyl chloride poisoning. He was admitted to the ward and within about one week all these symptoms had practically disappeared, excepting for the " peculiar, acidulated,

ghastly " taste. He was then able to give a much fuller account of his illness. I should like to mention at this point that SO_2 and also ammonia gases have been almost entirely superseded by methyl chloride as a refrigerator gas in certain types of domestic and commercial refrigerators. This gas is almost entirely inodorous and non-irritating and possesses certain physical properties rendering it particularly suitable as a refrigerating agent. This patient had been working long hours and was inundated with work, particularly during the summer. He was apt to rush through it and was inclined to omit some of the recognised precautionary measures when handling methyl chloride, with the result that he was frequently liable to inhale the gas in large quantities.

(To be concluded.)

Sector News

Guy's Letter

THE Park, usually one of London's quieter spots, has lately resounded to the harsh sounds of the parade ground—the hoarse words of command and the tramp of heavy boots as the Hospital Home Guard are put through the elements of drill. That the military should so invade the precincts of the Hospital is, no doubt, nothing extraordinary in these times and certainly reminds us that there is a Home Guard in connection with the Medical School. Their activities have not, of course, received publicity in these pages, so that their appearance in the Park, which provides a fascinating spectacle for the patients on the balconies and others besides, gives us some indication of their keeness.

The residents have been joined by Masters and Arthur Williams as O.P.O.'s, while Stevens is busy anæsthetising; Merrick has joined Gardner as H.P. Apparently two floors of Nuffield House are soon to be opened again to private patients and the residents are to forsake the luxury of Nuffield for less palatial quarters in Doyle's House, a quiet backwater of whose existence many were until recently unaware. Before having the roof burnt off in the " blitz," it was used by the nursing staff, some of whose names are still on the doors of the rooms. Nuffield has already been attacked by the works department engaged in preparing the rooms and the noise of hammering from the roof at what is for many an early hour has disturbed that part of the night's rest which keeps us late for breakfast.

The reopening of Nuffield is but one sign of increased activity and at times there is quite acute pressure on the bed space, which means that patients on the waiting list for beds, who do not require urgent treatment, have sometimes to wait longer than they expect and feel they have been forgotten. A number are sent to base hospitals for treatment, and those in the wards who are fit for evacuation are sent to the bases also, but even with this it seems that a larger number of beds than are at present available are necessary to cater for the volume of patients.

The children's ward is soon to return to its old home in Diplock, which will be a lighter and airier place than the present basement. The latter is to be retained as an air-raid shelter for Diplock.

R. I. M.

Hurstmead Letter

AS this is the first letter ever to be written from this outpost of Guy's, I had better explain that Hurstmead is a students' hostel in Tunbridge Wells. We have consistently been forgotten (or ignored) by the writers of the Tunbridge Wells letters, and so have at last decided to fend for ourselves. There must be many students who have stayed here in the past and who will be very pleased to hear from us.

Just over a year ago we broke fresh ground and held a Christmas dance. It was very successful and we decided that no longer should " beautiful " women be barred from Hurstmead festivities. Since then we have never looked back; last summer we passed further afield and held a garden-party, which consisted mainly of " comic sports," followed by tea and dancing. Everyone seemed to enjoy themselves, especially certain members of the staff and their wives, who caused much amusement by entering for such contests as the sack race and the wheelbarrow race. Last December we held a second Christmas dance, and nurses and students were once again seen dancing

together, this time, however, beneath a canopy of magnificent decorations to the accompaniment of soft lights and sweet music.

This term we have revived the Hurstmead Debating Society. It has been well supported, and the first debate, under the chairmanship of Mr. Wilkie, gathered an interested audience. The motion was that "This house disapproves of the principle of marriage." It was defeated by a large majority, showing that there still lingers some conservative atmosphere amongst students. The second meeting of the society took the form of a mock trial. The charge was one of murder and the case was adapted from an actual trial held some years ago. The evidence against the accused could not be called strong and there ensued a fierce battle between the two counsels. The judge's summing-up was rather unfair, but perhaps he may be excused on the grounds of inexperience in legal matters. However, the spectators (and the judge) got what they wanted, as the jury returned a verdict of "guilty" and the death sentence was passed with all the vehemence and sadistic pleasure of a Judge Jeffreys.

Next term we look forward to further activities and, as soon as the weather is fine enough, we hope to hold another garden-party. P. F. S.

Correspondence

TO DENTAL STUDENTS.

To the Editor of the GAZETTE.

SIR,—To-day one works to exist because one has to do so. Few people are able to pursue (or at least do pursue) what they should like to do as a livelihood. The world, besides rotting with war, is overcast by repressions, depressions, inhibitions, *diverted and sublimated instincts, irrational artificial and unnatural, commercially* produced environments. In this decaying, patched up, but nevertheless rotten world we live a life of greed, hate and lust. Where are we and why? What is this life all about and can we ever understand it?

No; we do not really know what life is, and a test-tube tobacco virus is a long shot off the mark. You and I and generations to come, yes all of us in fact, we shall do our share of work—our share allocated to us by never-dying tradition—and then after spending most of our short useless lives, take our modicum of rest and pleasure. The only certain thing in this uncertain world is ultimate death, and in this we shall all have an equal and generous share.

Considering all this, how can one be as apathetic and indifferent to one's fellow creatures as are the students of this Hospital. This indictment I level at the dental students as a whole. One would assume that educated, intelligent beings would learn a lesson from the vast amount of neglected dental disease that they survey. But no, their mental vista is limited to the oral cavity. Yet just a little of this specialised knowledge (so much of which is devoured and rarely used) intelligently applied to the present-day extra-dental world would doubtless be of inestimable value.

Of course, before one can "conveniently" aid others, one must put one's own house in order. However, we shall never do this as long as universal apathy and lack of appreciation of values is so rife throughout the dental school at Guy's amongst staff and students.

We are the biggest school of dentistry in this country and we have the opportunity of becoming the leading school, not by sheer weight of numbers alone—for one keen, intelligent working man is worth a boat-load of dull apathetic Guy's men—but by using the facilitities that are open to us.

We have a Dental Society, but its meetings are poorly attended. Surely out of the several hundred students who "choose" dentistry as their purpose in life more than a score are interested in "paradontal disease," for example. But apparently this is not so.

Must dental students be shown "coloured-snappy-movies" and "shorts" about dentistry to get them interested in their chosen profession? We are rapidly approaching this state of affairs, as indicated by the number of students that attended the two colour films recently shown at this Hospital: the one on contact lenses and the other on porcelain jacket crowns.

It is well-nigh time that the dental students of this Hospital stimulated themselves and, in so doing, produced something besides a few polished metallic fillings and some gaping extraction sockets.

If any of the apathetic souls to whom I refer are truly indifferent through design and not lethargy, I should like a reply to this letter. I sincerely trust there are none.

Yours, etc.,

Guy's Hospital, S.E.1. "SYNOPTIC."

HOME-GROWN DRUGS.

To the Editor of the GAZETTE.

SIR,—Last year the Pharmaceutical Department attempted to augment the supply of home-grown drugs by planting a plot in the Park with belladonna and hyoscyamus. The season was not a good one and the results were disappointing. This year the belladonna, being a perennial, has shown vigorous growth and, if the equally vigorous crop of aphis can be defeated, should yield a useful quantity of leaves.

Also last year a number of friends living in the country sent us a considerable quantity of digitalis (foxglove) leaves. Unfortunately we have not the facilities for undertaking the biological assay necessary for this drug. We must, therefore, very reluctantly ask these very good people not to send digitalis. We should, however, be very grateful for any quantity of belladonna (deadly nightshade), hyoscyamus (henbane), or stramonium (thorn-apple) leaves and flowering tops. In each case the drug should be collected when in flower, dried a little in the sun and sent to the dispensary as soon as possible after collecting.

Any efforts in this direction will be very much appreciated.

Yours, etc.,

Pharmaceutical Dept.,
Guy's Hospital, S.E.1. J. MOORE, Chief Pharmacist.

A CORRECTION.

To the Editor of the GAZETTE.

SIR,—"Uncle Harry" is wrong. The rule in the Army is that the medical officer has to certify that he is satisfied that a soldier is suffering from true epilepsy in order to invalid him out—not necessarily that he has seen him in a fit. This was the old rule, and a great nuisance it was; one always seemed to see an epileptic just recovering from a fit, having just missed seeing him actually in it. This rule was abolished in 1938 or before.

Yours, etc.,

BROOKE CHURCHILL, Lieut.-Col., R.A.M.C. (ret.).

RE SECTOR LETTERS.

To the Editor of the GAZETTE.

SIR,—The Tunbridge Wells Sector letter has of late been strangely non-existent in the *Gazette*. The authors consider this to be contrary to the interests of Guy's as a whole, in that the pre-clinical and clinical students seem, in their extra-studential activities, to be travelling in opposite directions. This was particularly noticeable at a recent meeting of the B.M.S.A., during which neither Sector could find common grounds of agreement with the other Sector. The writers feel that this is due, chiefly, to the isolation of the students here, in that they are unable to exchange views on subjects of mutual interest with the other Guy's men elsewhere. Under the present circumstances, the only possible solution to this problem would seem to be through the

columns of the *Gazette*. We therefore would like to suggest that the current ideas—*e.g.*, on the Beveridge Report, etc.—be included in the Sector letters in addition to the news of entertainments with which they have hitherto been almost solely concerned.

At the risk of being our own worst advocates we would like now to state that there are no prevalent feelings down here except a joyous anticipation on the part of the dental students, who will, it is rumoured, be soon returning to Guy's, and a corresponding despondency on the part of the medicals, who feel that they are about to be abandoned here in this desolate wilderness. Apart from this the cycle of the seasons continues and Spring has come, bringing as usual the spasmodic dances, glaring old-school blazers, and ceaseless cuckoos, which are as much part of the Spring as the tulips or May sun It but remains for us now to quote the theme song of the poor forlorn medicals :

" We dwell where youthful brains grow ripe,
A town not drained too well,
With here and there a choky pipe
And here and there a smell."

Yours, etc.,

RICHARD D. WALSH.
STANLEY J. HARRIS.

5, Sandrock Rood,
Tunbridge Wells, Kent.

James James Morrison Morrison Weatherby George Douthwaite
Took great care of his students though he was sometimes late ;
James James said to his students: " Students," he said, said he,
" You must never go down to the end of the ward if you don't go down with me."

J. J. M.'s students his good advice ignored,
J. J. M.'s students went on a round of the ward
J. J. M.'s students said to themselves in glee,
" We can get right down to the end of the ward and be back in time for tea."

P. B. put up a notice : " Lost, Stolen or Strayed !
J. J. M.'s students seem to have been mislaid.
Last seen wandering vaguely : quite of their own accord,
They tried to get down to the ward for a round—Forty shillings reward ! "

J. J. M. M. (commonly known as Jim)
Told the other physicians not to go blaming *him*.
J. J. *said* to his students, " Students," he said, said he,
" You must *never* go down to the end of the ward without consulting me."

J. J. M.'s students have been given up as dead.
P. B. said he was sorry, so did Winston and Ted.
P. B. (somebody told me) said to a man he knew :
" If people do down to the end of the ward—well, what can *anyone* do ? "

(Now, then, very softly) :

J. J.
M. M.
W. G. Douthwaite
Took great
c/o his S . . . . . .
Though he was sometimes late.
J. J.
Said to his S . . . . . .
" S.", he said, said he :
" You-must-never-go-down-to-the-end-of-the-ward-if-you-don't-go-down-with-ME."

With apologies to A. A. Milne.

Mythozoology

By SIR HARLEY WIMPOLE, M.A. (Andaman), D.Sc. (Perim),
M.D. (Tristan d'Acunha), Hon. LL.D. (Spitzbergen), D.C.L. (Erewhon), etc.,

I WAS surprised, to say the least, to read an article on the above subject by Sir Robert Synjann, P.R.D. (Lond.), in your issue of May 1st, especially as it contained no reference to my own researches, upon which I founded the new science. As is well known it was their recognition of this work which prompted the University of Spitzbergen to confer their degree of LL.D. (Hon. Caus.) and the University of Erewhon their degree of D.C.L. upon me.

Sir Robert first came under my influence at an early age, when he joined my staff as *Lavator Ampullæ*, about the same time that Professor Reltih, whose work on the application of oil-bound pigments to domestic and commercial use had come to a rather ignominious end, and his future employment was the subject of doubt and speculation.

It is particularly appropriate that my interest in the subject was first excited by a Monograph on the Urinometer which appeared in the colums of your distinguished journal in the year 1938. The writer was a famous scientist and University don whose innate modesty constrained him to conceal his identity under the *nom-de-plume* of "Stanley." Its subject was the remarkable propensity inherent in all urinometers of coming to rest with the scale turned away from the observer. It was a peculiarity which I myself had often noticed without giving the matter a thought, other than the momentary annoyance which it occasioned.

I would strongly advise all mythozoologists to read the article, as it was contemplation of the facts therein contained which stimulated me to undertake the work upon which the whole science is based, a brief *résumé* of which may not be without interest to your readers and to Sir Robert himself.

I began my work by the purchase of 239 urinometers and, having filled a corresponding number of specimen glasses—an effort which occupied the better part of four days—one urinometer was placed in each specimen glass. When they had come to rest and were checked up, it was found that of the total number, 237 had done so with the scale turned *away* from the observer.

My next task was to discover how the remaining two differed from the other 237. To do this I opened the air chambers of the two *in vacuo* and passed the contained air through a special form of filter which I had devised for the purpose, with an automatic attachment for weighing the filter and any filtrate which may have been arrested. The mercury from the bulb was distilled or resublimed in another special apparatus and both distillate and residue were weighed and examined. In each case the result was negative. The stem containing the graduated scale was examined with similar result.

The remaining urinometers were then examined under similar conditions with meticulous care, every precaution being taken to eliminate sources of error or fallacy. The result was astounding. From everyone of them in the Torricellian vacuum I recovered a tenuous form which I was able to solidify at a temperature of –300 deg. C. whilst still *in vacuo*. These were carefully removed from the vacuum and the temperature was raised slowly. At –1 deg. C. there was a loud crackling noise and the tenuous forms immediately disappeared. Then began a remarkable series of phenomena. Milk went sour, eggs became "addled," clocks and watches began to gain or lose, petrol tanks of cars suddenly became empty, cheques were returned "R.D." from banks, the metal buttons on gentlemen's garments disappeared (greatly to their confusion), and it immediately became obvious that I had liberated strange forces which I was quite unable to control.

* * * * * *

(If any of our readers would care to discuss the matter further with Sir Harley Wimpole, he is at present in residence, suffering from therapeutic malaria, in the new block behind the Pathology building.—EDITOR.)

Sport

Cricket

Guy's beat a team drawn from "A" and "C" Divisions, Metropolitan Police, on Saturday, May 15th, by 67 runs. Guy's batted first and put up a very poor show against accurate but by no means difficult bowling. The wicket was fairly dry and, although perhaps not a perfect batsman's wicket, it certainly favoured the batsman. At 60 for seven wickets Guy's were in a bad position, but E. W. R. Alderman, scoring 57, and D. Nicholson, with 29, played very well to give us a final score of 158.

During the Police innings G. Hildick-Smith bowled very well but with no luck, taking two wickets. Many bowlers were tried and most of them took one wicket, the Police being dismissed for 91 runs. Our fielding was passable, but was never quick enough to save runs to any extent.

Team.—E. W. R. Alderman, D. C. Boyd, G. Hildick-Smith, G. W. Garland, L. D. Carton-Kelly, R. D. Rogers, A. R. E. Trist, D. Nicholson, P. C. Matthews, G. Thompson, S. G. Beaton.

Guy's beat Woolwich Garrison by 7 wickets on Sunday, May 23rd, at Woolwich. Woolwich batted first on a perfect wicket, but scored very slowly and were only 60 for three wickets at lunch. After lunch they did not do much better, but there was quite a bright stand of 42 for the ninth wicket. The innings closed for 164 runs. Our bowling was at all times accurate, and did not give the batsmen easy runs. E. G. Murphy bowled well with an analysis of 4 for 34. E. W. R. Alderman got three wickets for 30. Our fielding was fairly consistent, two good catches being taken in the slips.

Guy's had about twenty-five minutes' batting before tea, and in this time one wicket fell. After tea E. G. Murphy was unlucky to be caught at the wicket on the leg side, having scored 24. A third wicket stand of 110 then followed between D. C. Boyd and G. Thompson, both batting extremely well. The latter was stumped, having scored 56, with the total at 145. The opponents' total was passed without further loss and at close of play Guy's were 235 for four wickets. D.C. Boyd was bowled, having scored 83 and G. Hildick-Smith was unbeaten with 57.

Team.—E. W. R. Alderman, E. G. Murphy, D. C. Boyd. G. Hildick-Smith, G. W. Garland, G. Thompson, R. G. L. Brittain, L. D. Carton-Kelly, D. Nicholson, A. Brown, D. Saunders.

Guy's beat Overseas H.Q., R.A.A.F., by 62 runs at H.O.P. on Saturday, May 29th. The match was played twelve-a-side. Guy's batted first on a perfect wicket and the opening partnership yielded 54 runs. The medium-paced bowling of Sergt. E. Clacher, who took nine wickets for 58 runs, caused a collapse, however, and six wickets fell for only 30 runs. A partnership between D. C. Boyd (40) and A. Brown (16) retrieved the position to some extent, but the final total of 157 was very disappointing.

The R.A.A.F. were dismissed for 95 runs, this low score being due chiefly to the bowling of G. Thompson, whose final analysis was five for 14. E. G. Murphy took two fine catches, one off his own bowling and one in the slips.

Team.—E. W. R. Alderman, C. S. Gardner, D. C. Boyd, E. G. Murphy, G. W. Garland, G. Thompson, D. Nicholson, R. G. L. Brittain, L. D. Carton-Kelly, A. Brown, A. R. Trist, W. R. Hall.

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.
THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.
April, 1943.

Pass.

G. M. Coupland	J. F. Horley
W. G. Cross, B.D.S.	W. H. Humphreys
F. G. B. Dodd	R. I. McCallum
J. T. Doyle	I. S. MacLeod
W. Fox	A. C. Macrae-Gibson
G. H. Gilford	A. J. Shillitoe
D. L. Gullick	A. B. Stratton
M. F. Hart	H. Whitworth
E. O. Höhn, B.Sc.	E. A. Williams

Supplementary Pass List.

PART I.

B. B. Alhadeff	A. B. Lee
P. Brightwell	D. R. I. Mason
D. H. Broughton	R. Merryweather
R. R. Burn	J. K. Morgan
E. G. Cook	R. L. Ray
E. H. Couper	L. P. Ribet
M. J. Cutler	J. A. Riddle
A. G. Ellerker	D. Rosenberg
R. Finney	D. R. S. Saunders
G. W. Garland	R. S. Smith
K. M. Gough	W. H. Smith
H. F. Hills	I. T. The
P. W. T. Hollis	J. R. Trounce
W. C. Johnson	J. C. P. Weber
P. G. Large	L. P. J. Wright

PART II.

B. B. Alhadeff	O. M. Jonathan
R. N. M. Eminson	T. H. McCall
J. M. Fabricius	R. L. Ray
M. M. Figgis	G. F. Swann
I. D. Henderson	

PART III.

R. S. Smith	I. T. The

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
May, 1943.

Surgery.—A. M. Earle.

Conjoint Board

March, 1943.

PRE-MEDICAL EXAMINATION.

Chemistry.—E. H. Braun, A. B. de Hoxar, F. E. N. Preston, M. J. L. Sykes.

Physics.—R. K. Allday, A. T. Goldie, D. H. Griffiths, A. W. Hilliam, M. J. L. Sykes.

Biology.—W. G. Burvill-Holmes, R. E. Feaver, A. T. Goldie, P. C. Hadley, P. I. Holmes.

Biology.—W. G. Burvill-Holmes, R. E. Feaver, A. T. Goldie, P. C. Hadley, P. I Holmes.

Birthday Honours

KNIGHT BATCHELOR

Herbert Lightfoot Eason, C.B., C.M.G., M.S.

O.B.E. MILITARY DIVISION

Lieut.-Col. F. K. Escritt, R.A.M.C.

Change of Address

W. E. Robinson, M.D., 74, The Lawn, W.12. (*Tel.* : Shepherds Bush 3665.)

T. Wilson-Smith, M.D., 19, Marlborough Buildings, Bath. (*Tel.* : Bath 4745.)

Births

McCALL.—On May 8th, 1943, at Summercourt Nursing Home, Southborough, to Becky, wife of Surg.-Lieut. A. M. McCall, R.N.V.R.—a son.

TILLMAN.—To the wife of Dr. W. G. Tillman on 26th May, 1943, in London—a son.

Marriage

HOPKINS—BEST.—On May 22nd in London Philip Hopkins to June Best. New address : 58, Menelik Road, West Hampstead, N.W.2.

EDS. { J.O.L. R.R.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

IN our last number mention was made of plans for post-war reforms in medical education; such developments form a part of the generalised anticipation of a better world after the War which is reflected in such bodies as the medical planning commission and the Beveridge Committee. During recent weeks speeches in Parliament and letters to the current journals have drawn attention to an aspect of medical education which has had little enough publicity. This is an adequate health education, not of the would-be doctor, but of the multitude who will become his patients.

Mankind is at present accused of developing a cult of "negative" health by which illness and ill-health are accepted as essential concomitants of normal everyday life. Perhaps this is just another way of expressing the hoary old problem of the "bottle of medicine habit," but there does seem to be some truth in the suggestion that men and women to-day are "existing" rather than "living"; they are not realising to the full their capacities for actively creating and making something of life.

The counterblast of "positive" health is rather difficult to define and controversy was aroused when the term was first used in the interim report of the B.M.A. planning commission. It does not necessitate the extreme suggestion of Erewhon with persons charged with crimes such as "having developed consumption of the lungs," but it does call for a change in the general attitude both to life and to bodily functions. Such an attitude can only be produced by carefully cultivating that mental outlook which takes a pride in fitness and health, both as individual and communal assets. Previously health has been regarded almost entirely as an individual concern, with ill-health a personal burden; in the future, with the prospect of wide schemes of social security, the sick man will transfer much of this burden on to the State and his fellow men.

As with all reforms and improvements in life, adequate education is the factor of most importance. Primarily this is a matter for school education authorities, and, indeed, much has been done in late years, through the wider teaching of biology, to spread knowledge of life and better ways of living. Such acquisition of knowledge should not stop on leaving school, rather the reverse should be the case.

Adult interest in this respect is more difficult to attract and hold. The Central Council for Health Education was formed with this object. Recent efforts have been concerned particularly with the venereal diseases, but many subjects are covered in posters and booklets prepared by the Council and Ministry of Health. A further publication has just been sent to us, a new quarterly journal on Health Education. Several controversial subjects such as sex education, mental health and delinquency, are discussed and engaging points of view put forward. Many of these subjects may seem to be mere "sidelines" to students of medicine, but it should be remembered that the doctor, both in practice and the public health services, has important duties in advisory and educational capacities.

A MEETING of the Rugby Football Club was held recently to discuss plans for the club's centenary celebrations during the coming season. No definite decisions were announced, but the proceedings were opened by the President, the Dean of the Medical School, offering his resignation and proposing that Mr. W. D. Doherty, as one of the most outstanding personalities in Guy's rugger, be elected in his place. This noble gesture was very well received and the motion carried unanimously.

Mr. Doherty came to Guy's at the end of the last war as a Cambridge Blue and captained the XV for the three seasons 1919–1922. The captaincy has only been held for such a period by one other man—by W. W. Pinching in 1870. At the same time Mr. Doherty was captaining the Irish United Hospitals and Surrey XVs—a remarkable record—and it is most fitting that one so closely connected with the game should hold the presidency of the Club in its centenary season.

"The Frenzy"

A Clinical Lecture delivered by Dr. Simon Behrman on March 1st, 1943.

(*concluded.*)

HEAD INJURY AND EPILEPSY.

Dr. Symonds has drawn attention to the close resemblance between disturbances of cerebral function occurring in the post-traumatic and post-epileptic states. Depending largely on the violence of the fit or of the concussion, cerebral disturbances vary in severity, the range extending from automatism of brief duration to a state of coma. Here are some of these mental states which may be encountered, with the appropriate definitions suggested recently by the Brain Injuries Committee for the purpose of obtaining a greater degree of uniformity in the terminology used in case notes :—

Automatism.—A state in which the patient, though capable of responding normally to his immediate environment, subsequently has amnesia for the period in question. In this state there is always some degree of confusion with disorientation.

Confusion (clouding of consciousness).—Disturbance of consciousness, characterised by impaired capacity to think clearly and with customary rapidity.

Mild : A state in which the patient, though presenting the characteristic features of confusion in some degree, is capable of coherent conversation and appropriate behaviour.

Moderate : A state in which the patient, though out of touch with his surroundings, can be got to give relevant answers to simple questions, such as "What work do you do ?" "How old are you ?" "Where do you live ?"

Severe : A state in which the patient, though for the most part inaccessible, will occasionally show adequate response to simple commands forcibly given and, if necessary, reinforced by appropriate gestures—*e.g.*, "Put out your tongue." "Take my hand."

Delirium.—A state of much disturbed consciousness (confusion) with motor restlessness, transient hallucinations, disorientation and, perhaps, delusions.

This is how Percival Pott, some two hundred years ago, described traumatic delirium : "The patient gets no sleep at all, has a wild look, an eye much like that of a person who has long watched through apprehension and anxiety, talks much and inconsistently, has a hard labouring pulse, some small degree of fever and sometimes an inclination to vomit ; if not retained the patient will get out of bed and act with a kind of frantic absurdity, and appears in general much hurt by a strong light. A debility of understanding, an idiot look, a failure of memory are often present."

If present, traumatic delirium usually precedes the confusion. Both conditions, however, share many points in common ; both are subject to fluctuations, usually becoming more severe at night ; they may occur without blood being discoverable in the C.S.F., and without any appreciable rise in the C.S.F. pressure ; their duration varies within wide limits, from a few hours to as many weeks. The presence of mild traumatic confusion is often not recognised and this may have serious consequences, *e.g.*, the patient may be discharged at his own insistent request to return home, or a patient's statements and testimony while he is in this state may be accepted in good faith. Occasionally, on the other hand, post-traumatic dysphasia is mistaken for confusion ; it is, of course, possible for both these conditions to be present together. The not infrequent association of head and cervical spine injuries may be overlooked, and I have seen the quadraparesis in these cases put down to post-traumatic hysteria.

"The shock which the head sometimes receives by falls from on high, by strokes from ponderous bodies, does not infrequently cause a breach in some of the vessels, either in the brain or its meninges, and thereby occasions extravasation of the fluid which should circulate through them. To distinguish between an extravasation and concussion by the symptoms only is frequently a very difficult matter, sometimes an impossible one. The first stunning or deprivation of sense, whether total or partial, may be from either ; but when these first symptoms have been removed or have spontaneously disappeared, if such patient is again oppressed with drowsiness, or stupidity, or total or partial loss of sense, it then becomes most probable that the first complaints were from concussion and that the latter are from extravasation." . . .

The " extravasation " to which Potts refers (subdural or extradural hæmatoma, intracerebral or subarachnoid hæmorrhage), however, is not the only cause of delayed onset of " drowsiness, stupidity or total or partial loss of sense." Meningitis or fat embolism may also lead to such developments.

The nursing of these cases presents many difficulties. In delirium the patient may be violent and may have to be restrained to prevent injury to himself, but, on the whole, as little physical restraint should be used as possible in order to combat the restlessness. The bladder requires particular attention, and I will quote Donald Munro, who has put this point very well : " The patient's mental condition will not necessarily negative the training of a civilised life-time and permit him to urinate in bed. As a result his bladder distends and his discomfort increases because he does not or, perhaps, cannot communicate his situation to the attendants. His abortive efforts to reach a toilet are interpreted as an increase in inco-operation and the restraints are increased. Eventually his bladder overflows. This leads either to catheterisation or to the decision on the part of the attending surgeon that the passage of such small amounts of urine imply dehydration. All this can be prevented by early catheterisation, or often by merely placing a urinal in the appropriate position in the patient's bed."

INTRACRANIAL TUMOURS.

Mental symptoms usually appear after increased intracranial pressure has been present for some time, and therefore they are commonly seen in the later stages of intracranial tumours. The patient is dull, apathetic and torpid, yawning continuously. He is orientated, but pays little attention to what is happening around him. When questioned, he responds slowly and his replies betray a deficiency of memory for recent events. Since these clinical features are largely determined by raised intracranial pressure, they can often be relieved by hypertonic solutions which lower the C.S.F. pressure. For this purpose four to six ounces of half saturated solution of magnesium sulphate (a saturated solution, to which an equal volume of water has been added) can be used. The solution should be warmed to body temperature, slowly injected into the rectum and the patient encouraged to retain it as long as possible. More rapid reduction in C.S.F. pressure can be obtained by injecting 50 cc, of 50 per cent. glucose solution, or a similar volume of 15 per cent. solution of sodium chloride. These injections should be carried out slowly at a rate not exceeding 3 ccs. per minute.

Occasionally mental symptoms may appear early, even in the absence of any increased intracranial pressure. Often the patient is aware of these mental disturbances and may be much perturbed, but on occasions the patient may be completely insensible of any mental derangement. Some show apathy, indifference, lack of initiative and of spontaneity, others restlessness, talkativeness, light-hearted carelessness and slovenliness in deportment and dress. If a patient is engaged in work necessitating some degree of discernment, intellectual blunting and defect of memory may become revealed at a comparatively early stage ; in others, whose activities are of a more repetitive nature, no such deterioration in working capacity can be noticed. Often, however, it is only the husband or wife, brother or sister, or someone else in frequent and close contact with he patient, who alone is aware of slight personality changes which may have escaped the notice of others. It is not possible to assign any specific localisation to these tumours which give rise primarily to mental changes. They are generally situated in the cerebrum in such positions as to interfere with a large group of association fibres, without, however, giving rise to any focal signs. Deep-seated tumours of the frontal and temporal lobes and of the corpus callosum are particularly liable to give rise to this clinical picture. Pathologically these tumours are frequently gliomas, but may be metastatic tumours. A primary bronchial carcinoma should always be looked for in any patient past middle-age, who develops rapidly headache with confusion or drowsiness, rapidly passing into stupor. Here, for instance, is a case of this type. Ten weeks before admission the patient developed bronchitis, which was accompanied by fever, anorexia and malaise. A slight non-productive cough developed after this episode. These symptoms cleared up, but two weeks later he complained of generalised pains and headache. He became disorientated and gradually became increasingly stuperose. At autopsy the brain was found to be infiltrated by numerous small carcinomatous masses derived from a bronchial carcinoma.

ENCEPHALITIS.

" . . . Towards the end of 1916 the wards of the Vienna Psychiatric Clinic contained a number of patients with a strange variety of symptoms—cases which, apparently,

had only one feature in common—a difficulty to fit into any known diagnostic scheme. They had been admitted under the most varied names, such as meningitis, amentia, delirium, etc." . . . This is how Economo begins his classical monograph on encephalitis lethargica, but this difficulty of fitting cases into any clearly defined categories applies to *all* cases of encephalitis. If the term " encephalitis " is restricted to inflammatory disease of the brain of infectious origin, then theoretically, at any rate, it should be possible to classify cases of encephalitis according to the nature of the infective agent: (1) Neurotropic viruses: encephalitis lethargica, rabies, poliomyelitis. (2) Bacteria: spirochaete, pneumococcus, pyogenic organisms. (3) Parasites: malaria, trichinosis, cysticercosis, trypanosomiasis. However, many cases are difficult to fit into some such scheme; thus there is a large group of cases of encephalitis developing in the course of certain fevers, infections and exanthems—*e.g.*, measles, mumps, vaccinia, smallpox. Since much doubt prevails as to the exact causative agent responsible for the encephalitis in these cases, it is difficult to fit them satisfactorily into a scheme based on ætiology. The difficulties are even greater when the subject is approached from a clinical point of view. The clinical variations are so diverse as to offer no satisfactory basis for classification. However, the clinical group with which I am concerned at present is that in which frenzy is the most important presenting symptom. The possibility of encephalitis should be considered if, in addition to confusion of acute onset, the patient presents some of the following features:—

(1) Signs and symptoms of meningitis, *e.g.*, headache, neck stiffness, Kernig's sign; pleocytosis and raised protein in C.S.F.

(2) Signs and symptoms suggesting the presence of some focal lesions in the C.N.S., *e.g.*, epileptic fits, aphasia, motor paresis, cranial nerve palsies, cerebellar dysfunction, somnolence, etc.

(3) A history of febrile or influenza illness or of one of the exanthems or fevers, such as measles, mumps, vaccinia, pertussis, chickenpox, etc., preceding the onset of encephalitis.

It will be seen that differential diagnosis between encephalitis and meningitis must on occasions be difficult or arbitrary, since the two conditions are so often associated.

" Syphilis is fever diluted by time " and consequently the acute picture of encephalitis just sketched only rarely applies to syphilitic encephalitis, *i.e.*, dementia paralytica. Now that the incidence of syphilis has grown almost twice the pre-war figure, neurosyphilis will again become the pestilence it was after the last war, unless these cases receive adequate treatment now. That routine examination of the C.S.F. is essential in the proper management of every patient with syphilis is a point which cannot be stressed too much. No case should be considered as " cured " without a confirmatory examination of the C.S.F. On the extent of irreversible damage present at the time when treatment is commenced largely depends the result of therapy and early recognition of G.P.I. is, therefore, a matter of considerable importance. Delusions of grandeur, so often depicted in text-books, are comparatively rare; only about 15 per cent. of cases present this feature. In any case, the condition is so dramatic that it is unlikely to escape observation when present. It is the slow dementia, with the accompanying insiduous alterations in mood, temperament and behaviour (similar to those already described as occurring in cerebral tumours), which often pass unrecognised until the disease has made calamitous inroads.

I find that in the diagnosis too much importance is frequently attached to the presence of signs of tabes dorsalis. Though the two conditions are often associated, this is by no means always the case. The physical signs most commonly present in early cases are tremor of tongue, lips and hands, and dysarthria. It must not be forgotten that children in their teens may fall victims to this disease in congenital syphilis.

The question of brain abscesses can be conveniently discussed at this point, since they may be regarded as instances of suppurative encephalitis. Cases in which mental symptoms predominate fall, broadly speaking, into two groups—(1) the metastatic group, in which the septic material reaches the brain by the blood stream; these cases often have a fulminating onset, the most frequent sourse of infection being the lungs, *e.g.*, bronchiectasis. (2) Frontal lobe abscesses in cases of frontal and ethnoidal sinusitis.

DEFICIENCY DISEASES.

(1) *Avitaminosis.*—As I have already mentioned, the brain cell depends for its source of energy entirely on carbohydrates and, therefore, deficiency of either Vitamin B_1 or of nicotinic acid, if sufficiently severe, causes profound disturbance of cerebral function, since both these vitamins constitute important links in the oxidation of carbohydrates. Reference has already been made to the Korsakow syndrome, caused by Vitamin B_1 deficiency, and now it remains to say a few words about pellagra. This is a complex clinical syndrome presenting many different features and probably dependent on the deficiency of several vitamins contained in the Vitamin B complex. Of these nicotinic acid, riboflavine and Vitamin B_1 are the most important. The mental symptoms of pellagra seem to be related to deficiency of nicotinic acid. Recently claims have been made that many cases of frenzy, even among non-pellagrins, can be relieved by the administration of nicotinic acid in adequate doses. This form of treatment should prove of value in those cases of frenzy which show clinical evidence, even minimal, of Vitamin B complex deficiency—*e.g.*, glossy tongue, chapped and shiny lips, linear fissures at angles of mouth, reddening of conjunctiva, mild dermatitis of varying extent around nares and eyes, or in some cases where some degree of avitaminosis can be presumed to exist, as in old people, chronic alcoholics, or in-patients presenting some gastro-intestinal lesion likely to lead to diminished absorption of vitamins. It has been claimed, however, that even when such overt or covert evidence of vitamin deficiency does not exist, nicotinic acid may yet prove effective in some cases of frenzy, and recourse to a therapeutic test has been advocated. The innoxious properties of nicotinic acid are probably the only grounds on which this practice could be justified.

(2) *Deficiency of Castle's "Factor."*—That deficiency of Castle's factor may lead to frenzy in the absence of any clinical evidence of spinal cord or peripheral nerve involvement is, perhaps, not as well recognised as it should be. I was recently asked to see a patient who had shown symptoms indicative of a progressive confusional state for about a year. On admission, though orientated, his conversation was disconnected, his answers irrelevant. His mood was elated and he laughed inordinately at the slightest provocation and sometimes without it. He walked unsteadily on a wide base and his limbs were "tremulous." The mucous membranes were pale and examination of his blood reveal d a typical picture of advanced macrocytic anæmia, which, however, had not been connected with his mental state and had not been treated adequately. He rapidly became stuperose and, when I first saw him, he was in deep coma. Unfortunately, before the liver therapy could prove effective, he succumbed to broncho-pneumonia.

The degree of mental affection in these cases is extremely variable. There may only be a slight alteration in the personality of the patient, perhaps an increased irritability or a greater proclivity to weep. In some paranoid delusions may appear, others may develop disturbances of memory or hallucinations. The investigation of any case of obscure frenzy should, therefore, include an examination of the blood. Perhaps I should add that the mental changes are directly attributable to the lack of Castle's factor, and are not due to the diminished hæmoglobin content of the blood.

FRENZY IN THE AGED.

Now that both the relative proportion as well as the absolute number of persons over sixty is on the increase in the population, this subject is assuming greater importance. Clinically, these cases can be divided into two groups—(1) cases in which the frenzy runs a chronic and usually a progressive course; some of them are due to cerebral arterio-sclerosis, some are cases of true "senile dementia" of the type in which characteristic histological changes in the brain have been described. In most cases the differential diagnosis between these two pathologies is not possible at the bedside. (2) Cases in which the frenzy constitutes an episode of shorter or longer duration. Some of these are clearly post-apoplectic in type, the frenzy temporarily following a typical cerebro-vascular accident. Other cases have been described under the name of "senile delirium." Older people are more susceptible to frenzy, possibly as a result of diminished resiliency and reduced capacity for adjustment to a changed environment. Sometimes a definite precipitating factor is present—*e.g.*, prolonged recumbency in bed following a fracture; sometimes no such cause is present. The condition usually commences with restlessness at night and drowsiness during the day. The mental and physical signs of an acute delirium then appear—viz., delusions,

hallucinations, incontinence, tremor and slight fever. Often these patients show evidence of dehydration and, if present, this should be treated energetically with intravenous injections of 10 per cent. glucose administered by the drip method. Senile delirium is liable to spontaneous recovery, but, on the whole, carries with it a high mortality rate. In the treatment of these cases it is important to eschew all the usual hypnotics and sedatives. The pathology of senile delirium is probably heterogeneous, but we know very little about it. It is, of course, possible for senile delirium to be superimposed upon existing cerebral arterio-sclerosis or senile dementia.

HYPERTENSIVE ENCEPHALOPATHY.

In the past this condition was known as " acute uræmia," but the cerebral symptoms in these cases are probably not due to renal failure, but are produced by a sharp rise in the blood pressure. This syndrome is seen in all the hypertensive states—viz., eclampsia, acute and chronic nephritis and essential hypertension. Clinically, the important features are headache, vomiting, amaurosis, epileptic seizures and often mental confusion, associated with papilloedema and retinal hæmorrhages and high C.S.F. pressure.

METABOLIC DISORDERS.

As occasional causes of frenzy, the following disorders of metabolism assume some importance when discussing this subject :—

(1) *Uræmia*, with renal failure (*e.g.*, caused by prostatic obstruction) or without renal failure (*e.g.*, following dehydration).

(2) *Acidosis and ketosis.*—Clinically, these cases are characterised by the presence of " air-hunger "—a feature of which is deep and slightly rapid breathing. Ketosis is seen in uncontrolled diabetes, acidosis in salicylate poisoning and uræmia. I need not add that the presence of ketone bodies in the urine is by no means proof that the frenzy is due to ketosis.

(3) *Alkalosis.*—This may be a sequel to intensive alkali treatment in patients with impaired renal function, or it may result from loss of HCl after prolonged vomiting had occurred. Slow depressed breathing and, occasionally, tetany may be seen.

PREGNANCY AND PUERPERIUM.

Clinically there is nothing distinctive which differentiates psychoses of pregnancy and puerperium from psychoses at other epochs of life. Little or nothing positive is yet known about the ætiology, pathology or prognosis of these cases.

ENDOCRINE DISORDERS.

Because frenzy may be a feature of all endocrine disorders, the hypothesis that all psychoses may be ultimately due to this cause has been entertained. Like many another hypothesis purporting to explain all forms of mental disorder on the basis of a single causative factor, it contains no more than a germ of truth. Frenzy as presenting symptom is by no means uncommon in myxœdema, thyrotoxicoses, hypoparathyroidism (following thyroidectomy), hyperinsulinism (pancreatic islet tumours). This makes it necessary that a careful survey of the endocrine system is made in every case of unexplained frenzy.

SIMULATED FRENZY.

Sir John Collie used to relate a story of a man who, when asked to plead in the Old Bailey, promptly stood on his head in the dock. Both the judge and jury not unnaturally came to the conclusion that anyone who could behave in such an extraordinary way at such a crisis in his life must be insane. The judge ordered the man to be detained in a mental hospital, from which he subsequently escaped. Later the man admitted having feigned insanity. Since the law demands that an escaped lunatic, not apprehended within a fortnight, has to be certified again by two doctors, his position was unassailable.

Arthur Edward Durham

The author of the following reminiscences, Miss M. E. Durham, is the daughter of Arthur Durham, Guy's surgeon, and is herself well known to many old Guy's men. She is an authority on the Balkan States, about which she has written several books, and readers will see that time has in no way dimmed her wit.

MR. ARTHUR DURHAM was Senior Surgeon at Guy's and Vice-President of the College of Surgeons. He was noted for his successful surgical work and was among the first to adopt antiseptic methods. I remember how he used to come home drenched to the skin after operating under a carbolic spray.

He was born at Northampton in 1833, the eldest of five sons. His father—a schoolmaster—put him into the Northampton Bank. But he was always bent on being a doctor. He managed to pass the London Matriculation, but his father refused to pay for his medical training. His maternal aunt Sarah, who had married a Dr. Eves, who practised in the West of England and who was childless, came forward with a sufficient allowance to permit of him entering Guy's as a student. But he had to do a good deal of journalistic and other work to make both ends meet. Excessive overwork permanently injured his health which was never strong. From the beginning he specialised in surgery. His great aptitude as an operator is shown by the fact that before he was qualified he operated successfully on a case of strangulated hernia in a lonely cottage by the light of a candle held by the dying man's wife. My father told me how she dropped the hot grease on the man's abdomen. There were, of course, no anæsthetics. He had seen the operation performed and had the pluck and skill to do it himself, there being no other help available.

Having started his own career he fetched his brother Frederic up from Northampton, and he, too, qualified at Guy's. Later my mother's first cousin, Alfred Turner, came to Guy's and practised afterwards as a general practitioner. My two brothers, Arthur Ellis Durham and Herbert Edward Durham, followed their father at Guy's. Arthur Ellis gave promise of a brilliant career and gained a gold medal at Guy's. To my lasting sorrow he died of virulent diphtheria contracted at the London Fever Hospital, where he was working. Alas, the anti-toxin had not yet been discovered. Both my brothers were enthusiastic students of bacteriology, then in its early days. At the same time Frank Heatheley, my second cousin on my mother's side, studied at Guy's. He had a large general practice in and near Liverpool and specialised in diseases of the heart. My brother, Herbert Edward Durham, F.R.C.S., never practised, but worked as a bacteriologist in connection with the Tropical School of Medicine.

The Guy's tradition continues in our family. My sister's daughter married William Trethowan, who was well known as an orthopædic surgeon, not only at Guy's, for his unrivalled skill. His two sons, W. M. Trethowan and J. D. Trethowan, have followed in their father's footsteps.

Thus I have been connected in one way or another with Guy's all my life. When very young we used to visit my father's wards, Martha and Lazarus. He had beds, too, in Cornelius and Accidents. He used to supply a vast Christmas-tree to Martha.

All the Guy's staff and many country practitioners—Guy's men—used to visit our house. Thus I have many recollections of Cooper Forster, Habershon, Sir William Gull Higgens, Jacobson, Pye Smith, etc., and, warmest of all, of Sir Samuel Wilks, who used to tell me interesting reminscences of the past. In those days all the leading surgeons and physicians lived in and around Brook Street and Grosvenor Street. I used to hear it asked, "Where is So-and-so?" "He! Oh, somewhere north of Oxford Street, I think—Wimpole or Harley." It implied something not of the first rank, and to this day it amuses me to hear "Harley Street" spoken of with awe. So do the wheels of time go round. But in spite of all changes and calamities Guy's still stands. May it long continue to do so!

Front Surgery; or Advice to Dressers

AFTER watching many generations of students struggling through the various appointments in their careers I feel that I may be able to give them some advice on how to make their duties more pleasant. I have decided this time to take the appointment of Senior Dresser.

Firstly, what instruments should he have ? :—

Stethoscope.—This instrument is not essential as a piece of rolled-up newspaper will do equally well, but there are uses for the rubber tubing.

A Ruler.—This must be narrow and about two feet long at least, preferably of the flexible steel variety, or it will not record the quantity of beer left in the barrel and will therefore serve no useful purpose.

A Pen.—This is not advised, as it is better to be thought dumb than to put one's ignorance in writing.

Diagnostic Set.—This display of wealth may impress the patient, but won't fool your examiners.

Scissors.—These are useful for cutting your nails, but without them one always has an excuse to engage a nurse of Type C (*vide infra*) in conversation.

A Timepiece, Clock or Watch.—This is essential ; it need not have a second hand, as it is always permissible to write down " Pulse 75 ; respirations 20," when in doubt, but it must be a good time-keeper or how else will you know where to find your surgeons.

With all these essential instruments firmly strapped to your wrist, you are now ready to enter Front Surgery. This department is situated in the south-west corner of the Hospital. It may be approached in many ways, but it is advisable to approach it soberly first time, except on a Saturday night, when you will not be noticed. Here, in Front Surgery, you will come across three classes of people—nurses, doctors and patients. For your convenience I will divide the nurses into three types—A, B and C :—

Type A, Sister.—She is the most senior of the nurse types. She is not to be found in the room marked " Sister," as that is full of doctors, but she will probably be sitting outside on a stool. She is to be adressed as " Sister." There will be no difficulty in recognising her as she is dressed in blue.

Type B Nurses.—Patients, for the care of.

Type C Nurses.—Students, for the use of.

I shall say no more about these.

DIAGNOSIS AND TREATMENT.

Throughout the years students have tried many different methods of interrogation. Some are very orthodox and approach their victim with the all-knowing, " Of what do you complain ? " Whereupon the patient says " Eh ? " or " What " ? And as I have never seen the student with sufficient nerve to repeat the phrase, you might just as well start with " What's the matter ? " especially as there is just a chance that it's a recurrence of some disease of which the patient alone will know the answer.

TREATMENT.

This is the easiest part of all. It falls into two classes :—

1. *Headaches and Vague Pains.*—Give two tabs. of A.P.C. or, if you think the patient is not impressed, put on a serious countenance and say : " Now I am going to give you a very new and strong drug, only two tablets ; one you will take now, the other exactly fifteen minutes before you go to bed." Then, in bold writing, so that the patient can see what you have written, write : " C.P.A. tabs. ii ; not to be repeated."

2. *Treatment of Lacerations.*—The standard formula for this is antiphlogistine and 3,000 units of A.T.S. Personally I have found two A.T.Ss. more than I could stand in one dose, but, then, I don't come from the Borough. These are about the only cases you are allowed to treat, so you have no further need to worry.

FILLING IN FORMS.

This is very difficult. Leave it to the O.P.O and let him take the blame.

Hoping that this advice will make your burden lighter, I must haste away to my own tasks.

Your loving,

AUNTIE FLO.

Correspondence

RE SECTOR LETTERS.

To the Editor of the GAZETTE.

SIR,—Let not your editorial heart be troubled at the thought of Messrs. Walsh and Harris poring over the Beveridge Report in an ill-drained and desolate wilderness. These forlorn gentlemen reside in a large house with bright airy rooms and all the conveniences provided by modern plumbing. The garden was beautiful, but a good deal of its beauty has been lost because its present tenants are so intoxicated with the unbiological slogan of social security that they think the spirit of Sir William Beveridge will descend each night to pluck out the weeds and tie up the rambler roses. So "secure" are they that they feel it is quite unnecessary to expend any effort to arrest the development of that very wilderness that they deplore.

This house is situated in a town which is extremely well appointed and comparatively undamaged. It possesses all the necessary amenities in the way of shops, cinemas, a library, and frequently a repertory theatre. The surrounding country is among the most beautiful in this island and good roads and frequent bus services make this countryside readily available to all. In this town we have some three hundred students so that the opportunities for intimate contact are greater than in peace-time provided the effort is made to create them.

No, Sir, Guy's has not dumped its pre-clinical youth in an unsanitary wilderness and there is little need for commiseration. When students learn to take a pride in the achievements of their school and, more important still, when they learn to contribute to and co-operate in that achievement, then they may legitimately claim the right of space in your pages—space which is reserved for those who have earned the title of "Guy's men!"

Yours, etc.,

6, Sandrock Road,
Tunbridge Wells.

W. R. SPURRELL.

P.S.—I have assumed that your correspondents referred to the physical state of their environment. I hardly feel that they would have discussed their mental state with such candour.

GREMLINS IN GUY'S HOSPITAL.

To the Editor of the GAZETTE.

SIR,—We understand that you are interested in "gremlins." We have a most persistent and choice specimen in the ward room whom, we regret to say, must be reproducing at a surprisingly rapid rate, as there seems to be a family, if not a colony of them. Naturally any helpful suggestion leading to their banishment, or a trap to catch them red-handed, would be most welcome.

Their size must be small in comparison with their wickedness, as a tiny footprint was found on a counterpane; the gremlin must have just stepped out of a cup of tea. On the whole they are nocturnal visitors, though they have been known to whip off red blankets during the morning. They delight in crawling under the hot-air cradles, fusing the bulbs, and once were even known to remove an asbestos sheet. Another great game they play is hopping from bed to bed, pulling down the bed sacking tapes and leaving the curtain rings all willy nilly.

They have a pretty taste in medicine, Mist. Ipecac. Co. being the favourite—they once had one and a half pints in two days—and they are obviously anæmic, for they have taken at least one bottle of Ferri et Ammon. Cit. They certainly empty water from the water-beds and are very partial to milk. They are frequent visitors to Hilton, where the procedure is much the same.

What causes Sister great grief is the constant disappearance of soap from the doctors' basins, but she is considerably cheered when we tell her that they must at any rate be clean in their habits, for who else would dream of removing the soap?

We could write at length of their wilful and mischievous tricks, but having taken up much valuable space already, we sign ourselves

Yours, etc.,

THE STAFF OF THE EYE WARD.

Sayings and Quotations of Sir William Osler

The Student Life. A farewell address to American and Canadian Medical Students, 1905.

It is a common error to think that the more a doctor sees the greater his experience and the more he knows. No one ever drew a more skilful distinction than Cowper in his oft-quoted lines, which I am never tired of repeating in a medical audience—

"Knowledge and wisdom, far from being one,
Have oft-times no connexion. Knowledge dwells
In heads replete with thoughts of other men;
Wisdom in minds attentive to their own.
Knowledge is proud that he has learned so much;
Wisdom is humble that he knows no more."

* * * * * *

One of the most delightful sayings of antiquity is the remark of Herclitus upon his predecessors—that they had much knowledge but no sense—which indicates that the noble old Ephesian had a keen appreciation of their difference; and the distinction, too, is well drawn by Tennyson in the oft-quoted line—

"Knowledge comes but wisdom lingers."

Hospital Information, etc.

Notice

GUY'S HOSPITAL LADIES' ASSOCIATION.

The Forty-sixth Annual Meeting of the Guy's Hospital Ladies' Association was held in the Nurses' Home on June 8th, 1943, at 2.30 p.m., with Mr. F. N. Doubleday, Senior Dental Surgeon to the Hospital, in the chair.

Two hundred pounds was given to the Hospital towards the endowments of cots and 2,083 garments for the use of the patients. A reserve of £1,100 is being held on deposit.

Professor T. B. Johnston told the members of the importance of the Ladies' Association to the Hospital.

Miss Smith, O.B.E., gave an interesting account of the activities of the Middlesex Hospital Ladies' Association.

Mr. F. N. Doubleday, in an excellent address, spoke of the Dental Department, its part in the Hospital and of Keats, one of Guy's illustrious students.

K. G. B.

Pass List

UNIVERSITY OF CAMBRIDGE.

M.B., B.Ch.

May, 1943.

F. M. P. Eckstein.

CONJOINT BOARD.
FINAL EXAMINATION.
April, 1943.

Medicine.

*R. A. J Baily	*M. G. Marks
M. V. Doherty	*R. L. Ray
J. M. Fabricius	*T. L. Reeves
M. M. Figgis	*J. D. Trethowan
C. O. Fung-Kee-Fung	R. Webb
*G. H. Gilford	O. H. E. Williams
C. W. L. Jeanes	*C. J. Zerny
*I. M. MacArthur	

Midwifery.

P. K. A. Andrews	*J. A. Nissim
J. K. Argo	C. L. E. M. Sharp
A. Brown	S. Sheave
A. S. Carruthers	G. M. Turner
A. G. Ellerker	*S. M. Vine
N. L. M. MacManus	J. Wedgwood
J. L. F. Maine	

Surgery.

E. W. R. Alderman	*J. K. Ogden
J. K. Argo	*A. J. P. Oldham
*P. F. E. Brown	J. M. Thomas
S. Coffey	J. Wedgwood
D. J. Du Toit	*B. H. Wilshere
*G. H. Gilford	*K. L. Wilson
H. R. Lomax	R. M. Woodside
H. P. Merrick	C. F. Ziervogel
*J. A. Nissim	

Pathology.

R. A. Allen	C. O. Fung-Kee-Fung
D. H. Broughton	K. M. Gough
R. R. Burn	M. V. Guilmant
*M. V. Doherty	M. D. Keates
A. G. Ellerker	J. V. Kent

* Has completed the examination.

Change of Address

R. O. Barber, M.R.C.S., L.D.S., First Aid Commandant to the Casualty Service.

S. R. Trick, Lieut.-Col., R.A.M.C., 149th Field Ambulance, Middle East Force.

Births

BEHRMAN.—On June 9th, 1943, at 27, Welbeck Street, W.1, to Doris (née Engelbert), wife of Dr. Simon Behrman, 33, Harley Street, W.1—a son.

RUSHFORTH.—On June 10th, in Guy's Hospital, to Kitty (née Alkin), wife of Arthur F. Rushforth—the gift of a son.

WHITELEY.—On June 20th, 1943, at Whitecliffe Nursing Home, Whitecliffe Road, Parkstone, Dorset, to Eithne Elizabeth (née Dowling), wife of Captain E. Douglas Whiteley, A.D.Corps—a daughter.

Deaths

BANKART.—On June 19th, 1943, at Kenbrook, Star Cross, South Devon, Surgeon Rear-Admiral Sir Reginald Bankart, K.C.V.O., H.P.K., aged seventy-five.

EDS. { J.O.L. R.R.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

FOR this issue we will leave the present troubled waters of medical practice—to a few surface ripples of which we have drawn the readers's attention in the weeks past—and turn to history, the history of the *Gazette*. We are well aware that this has been written before ; in fact, it is to the researches of our predecessors that we are dependent for our own knowledge. but it has not been written lately and we feel that few of the present members of the medical school know much about it. We hope that some idea of our past may help them to evaluate our present position better. From those who have read the story before, from better pens than ours, we must ask patience.

The first *Gazette*, a twopenny weekly, was brought out through the private enterprise of a student, Mr. T. Cattell-Jones, in 1872. It is, therefore, the oldest existing students' journal in the country, and concedes only one—the long extinct London *Students' Gazette*—to have preceded it. Jones was helped by two other students, one of whom took over the editing the following year. During the next two years the *Gazette* struggled against a lack of enthusiasm in the Hospital, but in 1874 it came under the management of the Presidents of the Physical Society, who, representing a permanent body, gave it a continuity which it had hitherto lacked. Under these auspices it appeared weekly until December, 1875, then fortnightly until 1880. In this year came the first great crisis in *Gazette* history. The then editor took sides for the staff, in no uncertain manner, in a dispute with the Governors. As a result the publication was suspended by the latter and no further issues appeared until 1887.

In this year the lack of a Hospital journal was being felt more and more, and eventually permission was given for a resumption of publication. Only, however, on condition that a censor was appointed from the Hospital staff to prevent a recurrence of events such as led to the previous suspension. This office is now traditionally held by the Warden of the College. No one likes a censorship and disagreements are bound to occur from time to time between the censor and editor. Nevertheless it is probable that, even though the yoke galls on occasion, much trouble has been avoided in the last fifty years by his intervention.

Following the establishment of the new series the *Gazette* prospered, circulation increased, and with it the size of each issue. Also with the new series came illustrations, and in 1890 the opening of the new College by Mr. Gladstone saw the issue of a special number with pictures of the building.

In 1897 the *Gazette* separated from the Physical Society and formed a committee of its own, consisting of staff members, editors, manager, and a number of students, who are co-opted from each year. This body still runs the journal. Since this date the changes in the *Gazette* have been small and in the nature of a gradual evolution with the changing times, but another crisis must be mentioned. In 1933, following the defection of the then manager, it was discovered that the credit balance was, in fact, fictitious and the assets almost non-existent. By the exercise of much ingenuity and much hard work by the staff, publication was continued and debts paid off. A new manager was appointed and has ever since proved a source of help to editors in time of trouble, and has placed the finances once more on a sound footing.

Such is the story of the *Gazette*, the survival of several crises and a gradual rise to its present position. Now a third crisis has been hanging over us for the past three years, the difficulties of war-time production with paper restriction and other troubles. So far, although the size and number of pages in the *Gazette* have had to be reduced, we have carried on in as near an approach to the former standard as possible, and we shall continue as best we may until peace once more sees us with fifty pages—and the usual editorial struggle to fill them !

In connection with the centenary of the Rugby Football Club it is proposed to stage a match between Past and Present Guy's men at the beginning of the season. The provisional date is either September 28th or October 2nd.

Past Rugger players whatever team they played for, who are no longer at the Hospital, and who would like to be included, are invited to communicate with Mr. George Winston.

It is realised that those in the Services are uncertain whether they will be free on one of the above dates; nevertheless, they are invited to submit their names in case they are available.

There will be a full meeting of the Students Union, Wednesday next at 2 p.m., in the Physiology Theatre.

"The Literature"

By "G. L. D."

THOSE who have been wont from their early youth to pass some of their leisure moments in the delights of Literature (with a capital L) will remember the feeling, to say the least, of mild surprise when they heard for the first time someone refer to "the literature," and then proceed to give what was, in effect, a mere catalogue of morbid processes. One can remember one or two assistant house surgeons who had a weakness for this "kind of thing," but they will, no doubt, have grown out of it by now.

To make a learned contribution (liberally interspersed with references to "the literature") to some medical journals is one of the great ambitions of the embryonic consultant. A tensely-expectant world, he knows, will hang upon his words, and he must give them of his best. One can picture him, then, in the year of grace 1943, as he sharpens half-a-dozen goose quills (for Mabie and Todd's have gone out of business) and, as further armed with a jam-pot full of watery war-time ink, he squares his elbows and gets busy. Quite unconventionally he heads his article "The Brain Box," and, with a fine abandon, goes on:—"Brain storms, according to all the evidence, arise in the brainstorm area of the brain—that is, in the *Hippopotamus major*, somewhere near the back part" (Katzenjammer, Ortopopoff, Magenschmerz *et Al.*). At this point he falls back exhausted as "Joey" used to say, and decides to retire to the "Spit" for some Horlick's. *En route* he changes his mind and finally arrives at that adjacent caravansera the "Bee and Bonnet," which is reputed to exude the highest kind of inspiration, and where he may be left to imbibe it.

Two things will be noted in most of this kind of contributions to medical knowledge. One is that the person "Al," speaking algebraically, is a constant factor inside the brackets; the other is that it appears to be an infallible rule that the persons inside the brackets should be pure and undiluted foreign bodies, in much the same sort of way that an American will sometimes describe himself as a 100 per cent. American. It does not seem to matter how distinguished the home-grown product may be as an authority on the particular subject. He just gets left out of the picture. This, of course, may be only that pernicious kind of native modesty which, up till recent months, has blinded the world to our accomplishments in the present war.

The identity of "Al" has given rise to much speculation at different times, but the assertion that he is merely another Mrs. Harris has only to be stated to be violently refuted. Again, the name of Al Jolson, of tearful memory, has been suggested. Those whose memories will carry them back a matter of twelve years or so will recollect that he suffered from a species of lachrymophobia, or, what our ancestors would call, "an excess of the moist humours." Here, again, we would appear to be on the wrong track, for rumour has it that this Al was drowned in his own secretions a few years ago, and a good thing, too. No, Al is obviously a kind of universal wiseacre who knows all the answers to all the questions in all the subjects, and the indications point, with reasonable accuracy, to one person only—and that to the great Dr. Joad. One is not informed, even in "Who's Who" as to what the Doctor may be called in the bosom of his own family. "Al" (one is loth to say it) so obviously suggests that un-patrician patronymic "Alf," and one has a feeling that the Doctor at home, at any rate, would prefer to be called "George." No doubt the loquacious bore who accosted Horace on the Via Sacra on that sunny afternoon many years ago was called George. Somehow one always associates the name George with gregariousness and garrulity. But, alas, we are wandering into the mazes of Latin literature, and the contract was to discuss "The Literature." Besides, the Editor has said something about a paper shortage. However, perhaps we may be allowed to solve the mystery of "Al" in another issue.

"Infamous Conduct in a Professional Respect"

WHAT A PRACTITIONER MAY AND MAY NOT DO

By SIR HERBERT LIGHTFOOT EASON, C.B., C.M.G., M.D.,
President of the General Medical Council

A Lecture delivered to the Staff and Students of Guy's Hospital Medical and Dental School on Friday, June 4th, 1943.

GENTLEMEN,—When I look at a gathering of medical students I am always reminded of those lines by Gray in his "Distant Prospect of Eton College":—

"Alas, regardless of their doom,
The little victims play!
No sense have they of ills to come
Nor care beyond to-day."

But the moment you become qualified you have to give up all that lightheartedness and get ready for the great responsibilities which you have to meet.

During the whole of last week I was presiding over the session of the General Medical Council, trying and judging medical practitioners who have failed in their duties to an honourable profession, and I do not think there is anything sadder that I ever have to do than to announce the verdict of the Council to a doctor, telling him that the Registrar has been directed to erase his name from the Medical Register. It is turning a man out of an honourable profession to be an outcast from his colleagues. It is in the hope that no one of you here to-day will ever come before the General Medical Council that I thought it might be worth while to tell you a little about it while you are still young and irresponsible.

Most of you know that the General Medical Council is not the British Medical Association, a thing which the lay press have never managed to learn. The British Medical Association is a body which is set up for the benefit of the medical profession, both scientifically and professionally, as regards status, terms of appointment and general welfare. The General Medical Council was appointed in 1858, not for the benefit of the medical profession, but for the benefit of the public. The preamble to the Medical Act of 1858, under which the Council exercises its jurisdiction, is one of the shortest to any parliamentary Act. What it says is this:—

"Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified medical practitioners."

That was the whole substance of the Act. Before that Act was passed anybody could practise medicine or surgery, and nobody knew which of the many qualifications were good or which were bad. The passing of that Act has not, however, made medicine a closed profession. You are not protected, as are dentists under the Dentists Act of 1921, or midwives, or some other professions. Any unqualified person can still practise medicine and surgery, but the public must be enabled to distinguish between the qualified and the unqualified.

I have not time to tell you all about the General Medical Council. You can buy from the Council itself at the cost of one shilling a memorandum on its constitution, functions and procedure, and I quote from it to show you just what the Act did. The Act established a procedure for hall-marking the qualified practitioner so that he might be recognised when his services were required, but the public were left free then as now to seek medical advice and aid from the unqualified practitioner if they liked, and the unqualified practitioner was left free then as now to practise for gain amongst those who chose to employ and pay him.

I dare say you will have noticed that in this world, as it is, the idle and ignorant rich tend to go to the chiropractor and the osteopath who have large and expensive consulting rooms in the West End, while the ignorant poor go to the herbalist. Parliament has a greater sympathy, I think, with the unqualified practitioner than with the qualified. The mainstay of the medical profession is the solid middle class who go to their doctor as an expert, just as they do to their lawyer or architect or any other of their advisers.

The General Medical Council carries out its duty to distinguish between qualified and non-qualified practitioners. To do this it has to hall-mark the qualified practi-

tioner, guaranteeing that he has a certain minimum standard of knowledge which makes him fit to look after patients. Again, to enable it to keep up the standard of an honourable profession, it has to have powers for the disciplining of the profession so that dishonourable members can be removed.

The Council has, therefore, two functions. It has, first of all, an educational function. It inspects all the qualifying examinations of the licensing bodies. It issues recommendations as to amendments of the curriculum. But I am not going to deal with the educational side of the General Medical Council to-day. I want to talk to you rather about what a doctor can do and what he cannot do.

There are one or two important sections of the Act about which I think you ought to be fully aware. The first one of which I want to remind you is that when you are a qualified medical practitioner you can hold any theory of medicine or surgery you like. No licensing body can refuse to give you your degree or diploma because you hold unorthodox views. You can believe wholeheartedly in osteopathy and chiropractic, any heresy you like—you cannot be refused a degree or diploma for that. Equally the General Medical Council cannot remove you from the Register because you hold unorthodox views in medicine or surgery. Every registered medical practitioner is perfectly entitled to hold any views on medicine, surgery, and midwifery or on any specialty that he pleases. There is entire intellectual freedom. But there are certain restrictions as to the conduct of medical practitioners, and the important section which I am going to talk to you about to-day is Section 29 of the Medical Act, 1858. That Section 29 is quite a short one and I think you ought to remember every word of it :—

> "If any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall, after due inquiry, be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the Register."

That Section is in two parts. The first part relates to convictions in England or Ireland of any felony or misdemeanour or in Scotland of any crime or offence. It may interest you to know that from every magistrate's court, every court of justice, every police office in the kingdom, the General Medical Council obtains a notice of any conviction recorded against a medical practitioner. You may be convicted of keeping a dog without a licence, you may be convicted of driving your car without a licence, or of dangerous driving ; any sort of conviction is reported to us and is entered on your dossier. No action is taken with regard to most of these offences, but the Council cannot go behind the convictions. It is of no use a doctor coming and saying : "I was improperly convicted." We are bound under that Section to accept that conviction and, if the conviction is of a serious nature, we have to consider and may, if we think fit, direct the Registrar to erase his name from the Register.

Let me take a concrete instance. Supposing that you have knocked down and killed a man while driving a motor-car and that you have been tried and convicted of manslaughter. Manslaughter is a felony, and in due course your conviction will come before us. We shall have to consider whether the facts governing the occasion when you were convicted of manslaughter were such that you were doing something improper as a doctor. If we find that it was merely an accident, although it may have been dangerous driving or something of that sort, we shall probably decide that the doctor committed a civil offence for which he has been punished, but that it has nothing to do with us. But if a man is convicted of manslaughter and of being at that time drunk in charge of the car, then we might say : "Well, if a medical practitioner is accustomed to go about driving a car when he has drunk too much he is not a fit person to have patients entrusted to him," and we might erase the name from the Register.

We have to take convictions as proved, but we judge the circumstances of the case on its merits.

Now I come to the other part of the Section which relates to "infamous conduct in a professional respect." Here there may not have been any crime or offence for which the doctor was *convicted*. It may be that he has done something improper which he ought not to have done. What does "infamous conduct" in a professional respect mean ? The best definition was laid down a good many years ago by Lord Justice Lopes in the Court of Appeal, and has been of great assistance to the General Medical Council ever since. His definition was :—

"If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council if that be shown to say that he has been guilty of infamous conduct in a professional respect.

"The question is not merely whether what a medical man has done would be an infamous thing for anyone else but a medical man to do. He might do an infamous thing which would be infamous in anyone else, but if it is not done in a professional respect it does not come within Section 29."

It is with a view of giving you some indication of the sort of things you must avoid when you are in practice that the Council, when you are first registered, will send you a copy of their Warning Notices. Some of these copies have been distributed around the theatre. I did not expect that there would be so large an audience on this occasion or I would have had a larger number sent. None of you could do better than study these Warning Notices to see what to avoid. I am not going through them in detail, but at the present time one of the most important deals with certificates.

I was appalled when I used to live at Guy's to see house officers signing certificates in blank for sisters or nurses or dressers to fill up afterwards, saying that So-and-so was suffering from such and such a thing, and was unfit to follow his or her employment. If you do that sort of thing in private practice sooner or later you will get into trouble. I advise every one of you when you get into practice, however irksome it may seem, however many certificates you are called upon to sign, as you are in a time of national emergency like the present, never to sign a blank certificate and never to sign a document for the entire accuracy of which you cannot vouch. It is no good saying, "I have to-day examined So-and-so" when, in fact, you examined him yesterday.

I want to read the words of the Warning Notice. They are measured words :—

"1. The organisation of the resources of the nation for the combatant service generally, for the supply of munitions, for the mobilisation and use of labour, for public assistance, and for pensions, gives rise to a host of occasions on which registered medical practitioners are requested to sign certificates of fitness or unfitness for persons under their care. Such medical certificates, to be valid, must by law be signed by registered medical practitioners only, and this trust on the part of the State is dependent upon the maintenance of a reciprocal skill and good faith on the part of the practitioners.

"2. The State is accordingly entitled to assume that a certificate signed by a registered medical practitioner is completely reliable and an honest and proper fulfilment of his obligation.

"3. Unverified assertions made by the patient himself, personal opinions as to his fitness or unfitness for various forms of service, or for particular hours of work, and other statements not founded on a careful examination of the patient immediately before a certificate is given, or supported by ascertained facts or conditions, are not proper material to support a certificate signed by a registered medical practitioner as his testimony to facts within his professional knowledge."

If you will bear that in mind throughout your career and never sign a certificate if it does not meet with these requirements you will have done your duty to your profession and to the State. You will at times have a formidable number of documents which you are asked to sign. With regard to all of these you need to exercise the same meticulous care.

There are one or two other Warning Notices here. One of them relates to unqualified assistants. Unqualified assistants are now very rare, but you are not entitled as a registered medical practitioner to assist an unqualified practitioner in treating patients. If you do that you are traversing the whole aim of the Medical Acts, which is to enable the public to distinguish between the qualified and the unqualified practitioner. If you give an anæsthetic so as to enable an osteopath to treat a patient you are covering an unqualified practitioner, and that is infamous conduct in a professional respect. You must not assist unqualified practitioners to treat patients. You may ask me, "But cannot I ask a masseuse to massage a patient ?" Certainly you can. You can even ask an osteopath or a chiropractor to assist you in treating a patient, so long as the patient is under your own care. With that last proviso you can call in any unqualified person you like, but you are not entitled to give any assistance to an unqualified practitioner to enable *him* to treat a patient. That is where you

have to be careful to be quite sure that you are in no way assisting an unqualified practitioner to carry out his practice.

There are four other classes of "crimes" which often come before us. The commonest of all is drunkenness. You may be surprised to learn that the majority of the cases which come before the Council are those of practitioners who have been found guilty of being found drunk. Incidentally, if you are convicted of anything—drunkenness or anything else—I do advise you never to plead guilty. The person charged is sometimes advised to plead guilty because in that case no publicity will be given to his offence. It is true that no publicity may be given to it in the public press, but your conviction and your plea of guilty will be reported to the General Medical Council. The Council seldom takes a man off for being convicted of being drunk once, though he receives a warning. If he is convicted a second time he may receive a rather stiffer warning letter. If there are three convictions for drunkenness or cognate offences the Council may say: "This is a practitioner who habitually gets drunk and the question is whether he is a fit person to be in charge of patients." He will be summoned before the Council to answer a charge that he has been convicted three times of being drunk. It is an appalling sentence for a man who has been drunk three times to be removed from the Register, and therefore, unless the case is grave, the Council *may* suspend judgment and put the practitioner on probation for a period of one or two years, after which time he has to produce certificates as to his behaviour in the interval, and to give an undertaking as to his future behaviour. If his period of probation has been quite satisfactory, the Council may not remove his name from the Register. The Council does not ask him to make any pledge. It is not there to ask the members of the medical profession for pledges; its business is to give such practitioners time to think over what they have done and to realise the gravity of their offence and resolve to amend their ways.

If a practitioner is found drunk in charge of a motor-car the Council takes a much more serious view of it. Not only does such an offence show that he is inclined to over-indulgence in alcohol, but that it makes him so much less responsible because he thinks himself fit in such a condition to drive a dangerous machine like a motor-car. He is thus a danger to his own patients and to the public. The doctor who is found guilty of having been drunk in charge of a car once or twice may get short shrift at the hands of the Council.

The other three "crimes" you might remember as the three As—advertising, abortion and adultery. You will remember those three words. Advertising you are not allowed to do. Sometimes there appear in the Press nice little interviews with a doctor, little laudatory paragraphs showing what a distinguished surgeon or well-known physician he is, or little details about the persons whom he has attended, with a note that he has attended them. If those matters get into the Press with your knowledge and consent you may be summoned before the Council for infamous conduct, which will mean that you have permitted your merits to be advertised to the detriment of your more honourable and reticent brethren. I suggest that you should be suspicious of every journalist who comes to you for an interview and that you should be particularly careful if you are ever asked to broadcast, for you are then addressing an audience of about eight million people, and if you allow yourself to be described as a distinguished physician or surgeon your "crime" is greater. It may be immediately profitable to you and bring you a shoal of patients, but Nemesis can come more quickly than you may like. So there again, whenever there is any opportunity of advertising yourself do not permit it. I have been completely successful during the whole of my life in the official positions which I held, in keeping my name out of the newspapers, and I have found that if you are quite straight with the members of the Press on the subject they will respect your wishes. I have never minded their reference to such abstract beings as the superintendent of this hospital or an official of this institution, but the name must be kept out, and if you ask the Press to keep it out they will oblige you. But if you do let these things get into the papers—and you and I know some clever people whose names are seen comparatively frequently in the Press—it is advertising and will come within the purview of the General Medical Council.

As to abortion. You may have your own views, right or wrong, about birth control, and you may ask why, if birth control is permitted, abortion should not be permitted also, the one being only the sequel, a further step, to the other. Whatever your views about abortion you must remember that under the laws of this country abortion is a felony and punished by terms of penal servitude. There is hardly one of you in this audience who in your professional career will not at some time or other be approached by a relative, a friend or acquaintance who implores you to carry out an

abortion on a girl, who, possibly quite innocently and unknowingly, has been made pregnant. You are asked to save her reputation, and the credit and social standing of her family. It may be a near relative of your own ; it may be a friend of your childhood, and you may feel " I really do not think that this is an occasion on which I can refuse to save an unfortunate girl." You may do it quite safely once or twice and get away with it, but my advice to you is never, never, never to do it, not even for the one dearest to you in this world, and I will tell you why. Whatever the ethics of it, it is a crime. Whatever you may do or think, never do it, however great the temptation on sentimental or social grounds. Sooner or later you will be found out. One cannot keep on the Register a practitioner who has been convicted of a felony and sentenced to a term of imprisonment for that felony.

The last " crime " is adultery. The General Medical Council is no judge of morals. It is not there to punish the members of the medical profession ; it is there to protect the public. Before the last war divorce was very rare in the medical profession. That was because the social standards generally were very different from what they are now, and any doctor who went through the Divorce Court, whether as an innocent or guilty party, probably found his practice fading away. Since the last war divorce has increased enormously in every social stratum. Adultery *per se* is no concern of ours. It is not infamous conduct in a professional respect. The decree of a Divorce Court is not a conviction, it is a civil judgment. The General Medical Council takes no note of adultery *per se*. If, however, it is adultery with a person who is a patient or the wife of a patient or a member of a patient's family then the Council may say that the doctor has abused his position of trust. A doctor has opportunities of access to a woman's house and to her bedroom which are denied to the ordinary social acquaintances of the woman. If he betrays that trust, what husband can leave his wife safely at home while he goes to business and knows that the doctor is going to call ? I remember a case we had before us a year or two ago in which a parlour-maid gave evidence and in the course of it said that the doctor came to the door. She was asked how she knew he was the doctor, and she replied : " Oh, he had his little black bag with him ! " He was at once shown up to the woman's bedroom because he was a doctor. If you do not betray that trust and if every husband can feel that his wife, who is a patient of yours, is absolutely safe in your hands, then no imputation of infamous conduct in a professional respect can lie against you.

There is another side to all this. Doctors are extremely vulnerable to attacks by women who may accuse them of improper conduct, improper advances when they are being examined, and that sort of thing. Accusations of all sorts are made by malignant women who are often disappointed friends or lovers of the doctor. " Hell knows no fury like a woman scorned." One knows that there are women who will make most vindictive accusations about a medical man who, by virtue of the fact that he has to examine women in private in his surgery and consulting room, may have difficulty in rebutting the accusations unless he is very strict in obtaining details of corroboration on his own behalf. I urge you to be particularly careful what you do in this respect. If I may give a word of general advice—not a wasted word, for we have these cases coming before us—it would be that you should exercise the utmost caution in all that you do with regard to women patients. These accusations are the hardest things in the world to repudiate. I advise you that if you must have irregular relationships with any women you should keep those relationships right away from the professional side of your life.

Finally, to protect yourself against such accusations, I would urge that directly you become qualified you should join one of the well-established medical defence societies. They will advise you should any of these occasions arise, they will provide you with legal assistance and you will have some protection, which you may very well need, at any time during your career, from the day of your registration to the day you retire from practice. You will always be vulnerable to attacks of this sort unless you are extremely careful.

What it comes to in all your professional life is that you have to obey certain rules, and the simplest rule of all is the one that governs so much of our conduct as Englishmen. It starts in the public schools and goes through the universities and the learned professions and is summed up in the four words, " It is not done."

If during your professional life you are ever tempted to do anything which would transgress this code, do think to yourself " It is not done," and if, bearing in mind that you are members of a trusted and honourable profession, you always keep those four words in mind, you will never come before the tribunal over which I have at the present time the honour to preside.

Correspondence

PROPOSED LAMBRINUDI MEMORIAL.

The following letter has been received this week, and we feel that many Guy's men would like to associate themselves with such a memorial to Mr. Lambrinudi, one of which he would most surely have approved. Communications should be addressed to the Appeal Office in this case, mentioning the Fund.

SIR,—At the suggestion of friends a fund has been opened at Guy's Hospital to perpetuate in some suitable manner the memory of the late Constantine Lambrinudi, F.R.C.S., who did such valuable work for humanity in his capacity as Senior Orthopædic Surgeon to the Hospital, and was so universally and affectionately respected by all his colleagues and the patients who came under his care.

As a memorial it is hoped to endow a scholarship in orthopædic surgery in Guy's Hospital Medical School, to be known as the "Lambrinudi Scholarship Fund," or, should that prove impossible, either to endow a bed in his name in the orthopædic ward or to purchase orthopædic appliances for the poor.

It is felt that members of the Greek community in London might like to be associated with such a tribute to one of their most distinguished members, and we shall be pleased to receive and forward to Guy's Hospital any sums you may send for this purpose to either of us or, preferably, to Messrs. P. P. Rodocanachi & Co., 40–41, Old Broad Street, London, E.C.2.

Yours, etc.,

P. J. CALVOCORESSI.

G. M. MAVROGORDATO.

Guy's Hospital, S.E.1.

BIOLOGICAL FIGHT FOR EXISTENCE.

To the Editor of the GAZETTE.

SIR,—Concerning Dr. Spurrell's phrase, "the unbiological slogan of social security . . . . " There will always be a biological fight for existance even after the acceptance of the Beveridge Plan or, indeed, any other plan.

There is not, however, any necessity for this struggle to be conducted on the present lines, laid down somewhat arbitrarily by man, supplanting natural selection, possibly against the real requirements of man's place in Nature.

Yours, etc.,

MICHAEL KUGLER.

GUY'S MEN AND THE *GAZETTE*.

To the Editor of the GAZETTE.

SIR,—The statement of your correspondent, Dr. Spurrell, that space in the *Gazette* should be reserved for those who "have earned the title of Guy's men," betrays an autocracy and intolerance which, if truly the product of Guy's tradition, irrevocably condemns that tradition from the outset. Apart from the fact that preservation of freedom of speech and of publication is one of the alleged objects of this war, surely it is obvious that if the *Gazette* is to be truly representative of Guy's opinion and not express a merely sectarian view it must of necessity take note of student opinion, an opinion, after all, representing the vast majority of the resident population.

The reference to the "unbiological" Beveridge Report seems to imply that our lives, according to Dr. Spurrell, must be conducted not according to principles of social justice, but to the "biological" laws of the jungle—social insecurity and survival of the fittest. On such a philosophy I fail to comprehend the horticultural remarks of the writer. The garden in question is merely travelling to its own biological destiny—the jungle and wasteland—the Utopia from whence Mr. Spurrell derives his code of human behaviour.

Yours, etc.,

M. E. N. SMITH.

R.A.F. GREMLINS.

To the Editor of the GAZETTE.

SIR,—I have worked among the R.A.F. gremlins for about eighteen months now. They are extremely like their "Civvy Street" cousins. They go round on the days that the S.M.O. is inspecting, untidying bedside lockers as the Sister leaves them. They walk with muddy feet all over the newly scrubbed annexe floor; they have a positively devastating taste for toilet-paper, which they eat in large chunks, putting dirty newspaper in place of it. Always are they most hungry on the C.O.'s inspection day.

In closing I would add that I knew their forbears in Lydia and particularly in Mary—but in those days they confined themselves to baiting the junior probationer, or appeared to. They were just known as "devils" in those days.

Yours, etc.,

PRISCILLA JOSEPH (*née* CARBONALL).

P.S.—I have been asked to add that Miss Yvonne Levermore concurs with all this.

Reviews

Whitla's Pharmacy, Materia Medica and Therapeutics. Revised by J. H. BURN, M.D., F.R.S., and E. R. WITHELL, B.Sc., Ph.C. Fourteenth edition. Published by Balliere, Tindall & Cox. *Price* 14*s*.

IN this edition of Whitla's book the new arrangement of the therapeutics section, introduced in the last one, is continued and has been expanded by an added section on biological standardisation of drugs. This chapter, together with the one on biological variation, form an introduction to the scientific outlook on therapeutics, which is done better in few larger books on the subject. But few people using the potent drugs of to-day have any idea of the care needed to assess their effects in an accurate manner, necessitating well-controlled experiments on a large scale with statistical evaluation of the results. Even the least mathematically disposed of readers—a position to which the reviewer feels he has a fair claim—cannot fail to absorb something of value from these chapters. The rest of the therapeutics section has clear, if brief, sections on the chief classes of modern drugs, describing their modes of action and uses.

The pharmacy section goes into the compounding of medicines of all types in considerable detail. It contains much more than the modern medical student is apparently expected to know about the subject, and is therefore just the thing he will turn to when confronted in practice with the necessity of compounding, as well as prescribing, a mixture or ointment for the first time.

And, finally, the section on materia medica covers all the official preparations up to the date of publication, with the usual data.

This book is recommended to those in their final clinical year—or those already qualified—who want a handy book in which they can find the rationale as well as the pharmacopœal details of treatment. And if a number of them only read and digest the first two chapters mentioned above, we shall perhaps in future see less time, money, and space in the journals wasted on ill-conceived treatments, supported by unsatisfactory statistical or experimental evidence.

Sport

Cricket

On Saturday, June 5th, Guy's beat Middlesex Hospital by 8 wickets at Honor Oak Park. Middlesex batted first and scored 103 runs all out. These runs were knocked off in about an hour for the loss of 2 wickets, our score at close of play being 123 for 3 wickets.

Team.—E. W. R. Alderman, E. G. Murphy, D. C. Boyd, C. S. Gardner, G. Hildick-Smith, G. Thompson, R. G. L. Brittain, D. Nicholson, A. Brown, R. D. Rogers, L. D. Carton-Kelly.

Guy's took a team—sadly depleted by the call of exams. and the Whitsun holiday—to Camberley on Saturday, June 12th, and were lucky to force a draw with R.A.C. O.C.T.U., Sandhurst. Sandhurst batted first and declared after just over two hours with 148 for 8 wickets. This was surprisingly small and was due chiefly to Guy's fine fielding. Very good catches were taken by L. D. Carton-Kelly in the slips and D. Saunders, off his own bowling. We could not follow up this advantage, however, and collapsed badly when batting. We just saved the game, stumps being drawn at 92 for 9 wickets.

Team.—G. W. Garland, E. G. Murphy, G. Thompson, A. Brown, R. G. L. Brittain, L. D. Carton-Kelly, K. Pritchard, D. Saunders, R. Finney, D. Nicholson, D. Q. Trounce.

On Saturday, June 26th, at Beckenham, Guy's beat Beckenham by 10 wickets. Beckenham, 61 (Alderman, six for 24, including hat-trick); Guy's, 197 (Murphy, 62).

Team.—E. W. R. Alderman, G. W. Garland, E. G. Murphy, D. C. Boyd, G. Thompson, A. Brown, R. G. L. Brittain, D. Carton-Kelly, D. Nicholson, D. J. Sheerboon, R. Finney.

Against St. Thomas's Hospital at Honor Oak Park, on July 3rd, Guy's won by 70 runs. Guy's, 207 for 8 wickets declared (Saunders, 41; Sherboon, 36); St. Thomas's, 137.

Guy's passed the two hundred for the first time this season, and this without the help of two of their best bats. St. Thomas's bowling was, for the most part, steady but never aggressive, and the Guy's total was pleasantly divided out amongst the team. St. Thomas's were left an hour and three-quarters in which to do or die. It so happened they did the latter, but not without a struggle. After the second wicket had fallen Hudson-Bennett came in and proceeded to score in a delightfully carefree fashion, appearing every bit capable of getting the runs. After he was out it was left to Brown to dismiss the ball in three consecutive balls with ten minutes to spare. One bright flash in Guy's otherwise moderate fielding was a superb catch at gully by Finney—one of two he took in the afternoon.

Team.—E. W. R. Alderman, D. C. Boyd, G. Thompson, D. R. S. Saunders, A. Brown, R. G. L. Brittain, L. D. Carton-Kelly, D. Nicholson, D. J. Sheerboon, R. Finney, P. L. Brangwin.

Hospital Information, etc.

Notices

NUFFIELD HOUSE.

It is with pleasure that we inform our readers that two floors of Nuffield House are to be re-opened for the reception of patients and that by the commencement of September 27 rooms and 8 cubicles (35 beds in all) will be available, 18 of which will be ready as from August 3rd next.

NUFFIELD HOUSE.
RESIDENT MEDICAL OFFICER.

Applications are invited for the post of Resident Medical Officer in Nuffield House, two floors of which are to be re-opened shortly. Duties to commence on August 1st, 1943. Salary will be at the rate of £250 per annum, with board and lodging.

The post is recognised as a B.2 Appointment by the Central Medical War Committee.

Applications should be lodged in the Superintendent's Office without delay.

Those who have already applied, or propose applying for a B.2 House Appointment in Sector 10, are eligible for this new appointment, but must make separate application.

T. B. JOHNSTON,
Superintendent.

Pass List

ROYAL COLLEGE OF SURGEONS.
L.D.S.

FINAL EXAMINATION.

June, 1943.

PART I.—Surgery.

H. Barnett	J. C. Howe
N. J. Crane	B. H. Joyce
T. P. Dalton	M. M. Levene
D. R. Edwards	R. A. Ronchetti
R. J. Hart	

PART II.—Dental Surgery.

E. H. Archard	B. H. Joyce
R. H. Beare	E. Meissner
A. W. Bevis	R. Middleton
S. E. Blockley	G. N. Pleasant
C. G. Chester	J. E. Pountain
D. F. L. Cook	D. C. Steven
J. C. Cox	C. Sumsawaste
B. H. Dicker	N. J. Whelpton
J. R. Dimock	D. E. Williams
J. Elder	R. Woollcott
E. A. Glover	J. K. Yerbury
A. J. Goodwright	

ROYAL COLLEGE OF SURGEONS.
L.D.S.
May, 1943.

Dental Metallurgy.

I. L. Busbridge	P. H. Prynne
P. S. Holmes	J. R. Timms
E. T. Hunt	J. R. Waller
G. J. Marks	R. S. Wilson
R. A. Morsman	

Dental Mechanics.

J. E. E. Attale	P. S. Sutton
J. R. Burt	E. M. Sycamore
I. H. Hilliam	I. D. L. Thomson
P. C. Matthews	A. E. Trist
D. J. Reid	

Anatomy and Physiology.

R. Freeman	R. T. Lowein
R. A. J. Shaw	

Special Anatomy and Physiology.

C. G. Bason	J. B. Kyle
A. J. Bridge	K. M. Little
P. C. S. Campion	C. S. Matthews
J. W. Coombs	P. T. Parr
D. C. Dawson	J. S. Spencer
J. H. Farrell	A. G. Starke
H. E. P. Grabaskey	R. D. W. Stillman
P. J. Hill	E. H. Sudell
I. H. Hilliam	P. S. Sutton
F. B. Hickman	H. Wertheim
J. C. Howe	P. J. R. Whyte
R. E. Hyman	D. E. Williams
A. C. Keith-Fraser	

Change of Address

H. Millett, M.R.C.S., L.D.S., 112*a*, Harley Street, W.1. (*Tel.*: Welbeck 1038.)

Awards

BIRTHDAY HONOURS.

Miss K. B. V. Coni, Matron, Hull Maternity Home, O.B.E.

Miss M. Besly, Matron, Creighton Royal Hospital, R.R.C.

Births

GORDON.—On May 19th, at Farnborough, Kent, to Sally (née Allingham), wife of Ft.-Lt. John Gordon, R.A.F.V.R.—a daughter.

LUNN.—On June 29th, 1943, at Woking Maternity Home, to Agnes, wife of Major H. F. Lunn, R.A.M.C. (B.N.A.F.)—the gift of a sister for Christine (Rosalind).

Deaths

THOMSON.—On June 29th, 1943, the result of a motor accident, Charles Bertram Thomson, M.O.H., Wimborne.

EDS. { J.O.L. R.R.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

OUR last issue echoing the history of the *Gazette* has turned our thoughts to matters historical generally, and a few moments' consideration reveals the strange phase which the Hospital is at present undergoing. undoubtedly the strangest in its long and varied story. It is true that wards have been re-opened in Hunt's House, the York Clinic and Nuffield House, but with the unoccupied but ever-ready E.M.S. casualty beds and the blitzed surgical wards, the number of in-patients is still greatly reduced. The out-patients' departments also function at a lower pitch, and as a great many patients go straight to the base hospitals in the Sector they are lost—at any rate, by the student who likes to follow up those innumerable moot points calling for observation and investigation. Other students at the bases no doubt benefit by dealing with these cases, but the important link with the presenting signs and symptoms is lost.

Perhaps one of the oddest features of war-time Guy's is the varied horticultural efforts apparent in the Hospital. Mr. Layton's spirited appeal in our pages some twelve months ago to nurses and students to " dig for Victory " has not produced a notable response and few freshly turned furrows can be seen at H.O.P., but the Matron and others have struggled valiantly with the limited space in the Hospital. An interesting sideline here is the pharmaceutical department's efforts at growing belladonna and hyocyamus ; their progress was reported in the *Gazette* a few weeks ago. And Miss Addiscott's noble work in converting the eyesore of the disused shelters in the Park into a pleasing rockery must not remain unmentioned.

To return to the subject of the evacuation of the Hospital and medical school ; one aspect which comes to mind is the loss of contact between preclinical and clinical students. Many students have now been " at Guy's " for two years or more before actually working at the Hospital ; technical instruction is probably not much affected, but there is the danger of losing so much of the spirit and tradition of Guy's—which form such an important feature of one's training. It is this spirit which must be carried on to the post-war Guy's, in whatever form or shape the Hospital may be rebuilt.

Further changes in the staff are anticipated with the rumoured loss to the Services of several of the Registrars. We are naturally sorry to lose them as individuals, and doubly so when we consider those who have already gone and the crowded rounds they have left. The number of students remains at a steady level and, with a dwindling experienced teaching staff, the efficiency of the school as a whole must sooner or later diminish. Previous allusions to this matter have called forth accusations of spoon-feeding with innumerable lectures and classes—instead of the gradual " absorption " of medicine and surgery by contact with patients—in history taking and examination, but these changes are well-nigh inevitable with large and unwieldy firms and fewer patients. Twenty or thirty students on a round cannot all examine one patient.

SOME publicity has been given recently to the formation of airborne and paratroop sections of the R.A.M.C., units used for the first time in the Tunisian offensive. We are tempted to speculate as to whether the addition of a maroon beret to the drab khaki will attract the more sartorially-minded section of M.O.s joining the Services—a section, not in a minority we suspect, at present very loyal to the sleek and becoming uniform of the Senior Service.

WE have recently received a number of anonymous letters with varied Latin and *ersatz* noms-de-plumes ; we would remind would-be correspondents that letters, even of non-provocative and mild character, should be accompanied by the writer's name and address—although such identity need not and will not be published without the author's consent.

Burns

A Clinical Lecture delivered at Guy's Hospital by NILS L. ECKHOFF, M.S.

GENTLEMEN,—In the early days of the War the medical journals were saturated with articles on the treatment of burns and cases were daily being admitted to the Hospital, so that those of you who were in the wards at that time no doubt heard a great deal about this condition and the tremendous arguments that took place between different schools of thought. Now that the battle has died down there may be some of you who are not conversant with the views expressed, and as each and every one of you may at any time be called upon to treat cases in the near future, I should like to try to put things tersely and clearly before you to-day.

History.—It would be impossible to recite all the applications that have from time to time been used for burns, but I may quote from a text-book of 1884, when flour, starch, cotton-wadding, treacle, white paint, gum, solution of rubber are all mentioned. These were all designed to shield the patient from the air. The author of the book was well up to date in expressing preference for antiseptics—namely, boracic acid, salicylic acid and eucalyptus oil, which he calls non-toxic antiseptics. He also mentions the use of carron oil (linseed oil and lime water) in iron foundries. Carron oil was a popular remedy when I was a lad, and it is interesting to note that [recent experiments have shown that carron oil produces a much quicker healing and a much better scar than tannic acid; while other experiments in which various oils were tested for their healing properties showed that collagen regeneration was stimulated (sometimes excessively) by all the oils tested, but linoleic acid was the only substance which stimulated epithelial proliferation, whereas the other substances mostly delayed this essential process.

During the last war some progress was made with various types of wax, which were painted on with a big brush, and these substances were in use when Davidson introduced tannic acid in about 1928. The mortality of burns was immediately reduced, and tannic acid naturally got the credit, but I hope to show you later that it is not necessarily correct to give all the credit to this chemical. Other coagulants came into the field either with or without tannic acid—namely, silver nitrate, gentian violet and triple dye (gentian violet, brilliant green and acriflavine). Suffice it to say that coagulation therapy reigned supreme for most of the period between the two wars, and some of the modern text-books do not mention alternative methods. For some years before this war the value of saline as a method of treatment began to be stressed (the beneficial effect of sea-water on chronic lesions is well known), and I treated with great success a small boy in a continuous saline bath in Caleb Ward in March, 1939. Bunyan (a Guy's dental man) with the help of Stannard (the manufacturer) introduced coated silk envelopes, shaped for every part of the body, whereby saline or electrolytic sodium hypochlorite could be repeatedly washed over the burnt surface without disturbing the patient. I have some here to show you to-day. About this time the controversy was at its height, and people were divided into dry-bobs and wet-bobs, or soakers and non-soakers. Hudson and others found that the coated silk made an excellent dressing for raw surfaces, and used it for extensive wounds of the trunk where the Bunyan-Stannard envelopes were not very easy to apply. Following the success of plaster-of-paris in the production of granulation tissue in the Spanish war, it naturally had, and still has, its advocates in burn treatment and, quite recently, a new method, which can be called the compression method, has arisen, which produces excellent results. I cannot hope to describe all these different methods, but I hope to say something of most of them and attempt to crystallise for you the pith of the argument.

War-time burn cases fall into several very definite groups. Pilots of fighter aircraft are subjected to intense heat for a short space of time, and if they have time to get out of the aircraft, are found to have burns over an extensive area, usually the face, backs of the hands and sometimes legs, but not necessarily of very severe degree. Bomber crews usually have rather more severe burns, of approximately the same distribution. Soldiers and sailors may be subjected to flash burns of wide extent, and in the retreat from France some of them found themselves in the sea in burning oil, when the burns were a good deal deeper. Air-raid casualties, trapped near a source of heat, may have deep though localised burns. One woman had the whole of one buttock burnt off, down to muscle. Or they may be unfortunate enough to be burnt or scalded with boiling fluids, such as sugar, resin, chemicals or hot metals, when the burns are likely to be widespread.

Civilians may similarly be injured in industrial plants and munitions works in the absence of air-raids. We recently had a phosphorus burn at Guy's, and it is important to note in this connection that the new incendiary bombs contain phosphorus, and that any burnt area must be kept under water or warm sodium bicarbonate until all traces of the element have been removed. The Guy's patient was still smouldering some five hours after the burn. Other common civilian burns occur when clothes catch alight in children and the brunt of the injury is found on the upper chest and neck, leading to characteristic contraction in spite of all treatment, or when children catch hold of hot things and burn the palms of the hands, which, again, show great tendency to contracture formation. Epileptics form another big group, falling in the fire during a fit, when localised though deep burns are to be expected.

I have not mentioned the vesicant gases, for, fortunately, we have not seen many examples of this. After decontamination, the treatment follows the lines I shall lay down later.

Dupuytren described six degrees of burn—erythema, vesication, partial skin loss, total skin loss, burn of muscle, and a totally charred part. To-day it is more common to describe three degrees only—namely, (i) erythema and vesication; (ii) partial skin loss; and (iii) total skin loss. In the first degree the plane of cleavage is between the epidermis and the dermis, in the second halfway through the dermis, leaving behind sufficient epithelial cells in the sweat glands, sebaceous glands and hair follicles to allow patchy regeneration, whilst in the third degree the whole dermis is destroyed, and healing can only take place from the periphery, unless grafting is employed. It is very important to understand the distinction between these degrees for the whole conception of treatment depends upon this fact. It is, therefore, important to attempt to decide immediately into which degree any case falls, although this can be exceedingly difficult, and the greatest experts make mistakes, usually in the direction of underestimating the depth of the burn.

In any bad burn case certain stages can be recognised. The first is the stage of *shock*, and is sometimes divided into primary shock, due to fright and over-exertion, and secondary shock coming on rather later, say after six six hours. The signs are characteristic and include rising pulse rate, rising respiration, falling blood pressure, pallor, thirst and restlessness. The outstanding feature of burn shock is hæmoconcentration, which can be estimated from hæmocrit readings or more indirectly from markedly elevated hæmoglobin readings. This hæmoconcentration is due to loss of fluid from the burnt surface, which has been estimated at two and a half times the normal loss from the skin, and loss of fluid into the tissues spaces, which is easily recognised by the development of œdema. The external loss probably ceases after about forty-eight hours, but the œdema of the tissue spaces goes on for weeks.

Then follows a stage of *toxæmia*, during which certain profound chemical changes occur. In the blood sodium and chlorine are diminished, potassium and magnesium increased, while calcium is usually unchanged. There is evidence of acidosis, increase of non-protein nitrogen, and increase in blood sugar. In severe cases jaundice may develop, due to liver degeneration. The clinical signs are pyrexia, restlessness, raised pulse and respiration, pallor, vomiting, delirium, convulsions, coma and death. Death may take place from eighteen hours to seven days after injury.

If the patient survives this stage, a stage of infection is to be expected in untreated cases, with all the attendant signs and symptoms. It is noteworthy that during this stage the patient loses weight rapidly, becomes markedly anæmic, and that the loss of fluid from the burnt surface in the form of pus may be very considerable, often up to several pints a day. One curious and interesting complication during this stage is the development of a duodenal ulcer (Curling's ulcer), which may or may not perforate. The stages of shock, toxæmia and infection merge imperceptibly into one another, and while the first and the last are easy of recognition, the intermediate stage of toxæmia may be missed, and is certainly not completely understood. There is still a good deal of doubt as to its cause. Following Dale and Laidlaw's work on shock it was thought that this stage was due to the absorption of some histamine-like substance from the burnt area, and tannic acid has been credited with the powers of stopping this occurrence. But the stage of toxæmia can certainly occur in the presence of tannic acid. Wilson and others have injected fluid from the *subcutaneous* tissues of burnt rabbits, and produced pathological changes associated with toxæmia in other rabbits. Although the presence of a toxin is not generally accepted as proven, these experiments cast some doubt on the value of tannic acid in preventing toxæmia. Indeed, it has even been suggested that the tannic acid may be a factor in increasing this toxæmia.

Others maintain that the stage of toxæmia is simply due to infection, and it is certainly true that it is difficult clinically to distinguish the two stages, for if toxæmia is present infection is practically always present as well. It is well known that infection occurs in an open wound within six hours of infliction, and in view of the fact that a burn is nothing more than an enormous open wound, the potentialities of infection are equally enormous. Nevertheless, in cases where toxæmia is clearly marked, associated with enormous rises of blood urea, jaundice and liver degeneration, the picture is not like that of infection alone, but tends to resemble more that interesting condition of crush injury, which is also as yet imperfectly understood.

With this rather sketchy knowledge of the pathological processes underlying a burn, how are we to proceed with treatment. It is necessary to visualise treatment having to be carried out in varying circumstances : at a first-aid post, at some remote spot in the country during a campaign, on board a ship or in the desert ; or treatment may be carried out in a hospital not specially equipped for burn cases ; or in a special burn centre. It is well to consider the last first and work backwards.

Shock is treated by generous sedatives, copious drinks of hot sweetened fluids, general warmth and the administration of plasma. As plasma has been lost plasma must be supplied, and is nowadays usually available. Serum, made from dried serum and water, is equally valuable. As a rough estimation 50 cc. of plasma is required for every per cent. of burned surface, as can be estimated from Berkow's table. Roughly this is : Head, 6 per cent. ; both hands, 6 per cent. ; both feet, 6 per cent. ; both arms, 18 per cent. ; both thighs, 18 per cent. ; both lower legs, 18 per cent. ; front of trunk, 18 per cent. ; back of trunk, 18 per cent. In the absence of either of these saline may be given, or glucose, with proper control of the amount of sodium chloride given in twenty-four hours, by adding a drop of silver nitrate to urine samples. A heavy cloud indicates too much chloride. Oxygen through a B.L.B. or other mask may be helpful if cyanosis is detected. The value of DOCA (desoxycorticosterone acetate) is not yet proven. American observers advise daily white and red blood cell estimations, estimations of plasma protein, blood chlorides, non-protein nitrogen, urea nitrogen, plasma carbon dioxide, icteric index and blood cholesterol, but all this is hardly necessary. The blood pressure and hæmoglobin should be recorded frequently, a fluid chart studiously kept, and the urine carefully examined for albumen, ketones, hæmoglobin and bile. These investigations may help us to understand and treat the condition of toxæmia. Glucose should be given if there is any impairment of liver function. These measures are designed to combat toxæmia as well as may be.

The next care is the prevention of infection. There cannot be the slightest doubt that infection is the greatest danger to life. It has already been stated that, with the coming of tannic acid, the mortality dropped markedly.

Davidson did something more than to introduce tannic acid. He stressed the fundamental importance of *cleaning* the burnt area, and for the first time people could be seen giving the patient a general anæsthetic, attacking the whole burnt area with ether, ether soap, spirit, swabs, sponges and even scrubbing brushes. Thereafter tannic acid was applied in various strengths and by various methods. Drying was achieved by blowing on hot air from a hair dryer (a very unsterile method) or by adding silver nitrate or other substances said to dry more quickly than the watery solution of tannic acid. Surgeons vied with one another about the quality and suppleness of their tans, and about the presence or absence of infection. Suffice it to say that cracking of the tan is universally recognised, and further applications are advised and practised during the days following the original application. (A common method is to apply in turn 1 per cent. gentian violet, 10 per cent. tannic acid, and 10 per cent. silver nitrate, and to chase up cracks with further gentian violet).

It must be admitted at once that hundreds of cases are daily treated where this method produces excellent results. These are cases of first and second degree burns of flat surfaces, which do well with almost any method of treatment, *provided proper cleansing is carried out at the start.* I am going to suggest that Davidson's great advance was not the introduction of tannic acid, but the introduction of proper cleansing. Let me suggest that this is rendered all the more difficult by the usual chain of events before the patient gets into the operating theatre. At first the patient or his friends peer at the part, and then proceed to apply any of the archaic remedies mentioned at the beginning of this lecture. Then a doctor is called in, who again exposes the part and applies something out of a tube or a bottle. (There is no place for coagulants without preliminary cleansing.)

Then the patient is taken to hospital and some out-patient officer or house surgeon, or both, assisted by many dressers, have a good look, and possibly apply something different. The case is admitted and the registrar or surgeon or both, with the attending dressers, have another look. None of these many people have thought for one moment about putting on masks. Twenty-five per cent. of them may have streptococci or other nasty organisms in their throats.

I do not wish to decry the desire to look and learn, which is in all our hearts, but I do want to point out to you how difficult it is for a patient to avoid infection. Once, again, think of a burn as an enormous open wound, and treat it with every respect due to its size. No burn should ever be inspected, at any stage in its treatment, without proper masking of the personnel, not forgetting the patient's own nose. Is there anything wrong with tannic acid therapy ? Let me repeat that it is an excellent method for first and second degree burns on flat surfaces, after proper cleansing, but so are many other methods, and in some healing seems to be even quicker than under tan. In third degree burns tannic acid does not help in promoting healing, for the thick eschar has to be removed before the proper method of procuring healing, namely grafting, can be started. Even on flat surfaces the tendency of the tan to contract can be easily demonstrated, for it is this that causes the crack between the tan and the surrounding skin, which, if not sealed quickly, leads so easily to infection. On the hands this vicious tendency to contract may have the most serious effects. If the whole hand is burnt and enclosed in tan, the effect is that of wearing a hard glove that is one or two sizes too small. An intense cramp is felt in all the tissues of the hand, associated with throbbing, often requiring morphia for relief. In a few days this pain may pass, but its disappearance often indicates cessation of blood flow, with gangrene of a part or the whole of the fingers. I can show you pictures of a hand so encased, where the soft tissues are bulging through cracks in the enclosing envelope.

Oedema of the hand makes the situation worse. Even if gangrene does not occur, the enforced immobilisation in the hard glove may lead to permanent intractable stiffness of all the small joints, completely ruining a hand that is otherwise but slightly damaged. It has been argued that any loss of tissue in a hand is due to the intensity of the burn, and not to the method of treatment, and this argument is difficult to counter unless one has been able to observe the case from the start. Suffice it to say that I can show you pictures of a pair of hands completely crippled by stiffness, with shrunken and tapering fingers, where the burn was of second degree only, but encased in tan.

Tannic acid is also contraindicated on the face and in movable parts, like the flexures, and in the perineum. In these parts where movement cannot be prevented cracking inevitably occurs, and in spite of the most assiduous attention infection inevitably follows. In this context I might point out that once infection occurs it is in my opinion very unwise to apply more tan, for this, if effective, only seals up the pus. Although we now once more hear talk of " laudable pus " in the treatment of soft tissue and even bony injuries, and although we know that the closed plaster method is quite useful in helping to fill up a cavity with granulation tissue, we know equally well that pus is inimical to the growth of epithelium, and is to be abhorred in burn treatment. For this reason I can see no place for secondary tanning—that is, tanning when infection is either obvious, or can be presumed with the passage of time. I would like you to look for a moment at this picture of a facial burn treated with tannic acid. The whole facial area is one mass of cracked tan and scab, with pus pouring out at every crack. The eyelids cannot move for they are covered with filthy incrustations. The ears, the nose and the mouth are similarly covered. The smell is indescribable and the agony of the patient intense.

Let me remind you that the greater majority of war-time burns are of the exposed parts, the hands and the face. Having seen hundreds of such cases I can assure you that the best method of treatment is the *saline bath* method. In a proper burns centre these cases are all immersed in a saline bath, with continuous saline at about 100 deg. F. being constantly added at the rate of one or two gallons a minute. All previous dressings are allowed to soak off slowly and coagulants (if previously applied) are removed slowly, often taking a week or two to get off. When dressings are off the patient is allowed to remain in the bath for as long as possible. In a busy centre this is usually between half and three-quarters of an hour, but this can be prolonged to several hours, and I have told you of a child that was treated in such a bath practically continuously. When the patient is taken out of the bath he is placed on his bed on a sterile sheet and rapidly dried off under a lamp. The raw surfaces are sprayed with

sulphanilamide, vaselined net material is applied, and the whole covered with many layers of sterile gauze. The gauze is moistened with saline every two hours and the bathe is repeated once or twice a day. There is nothing magical in this treatment. It is merely an attempt to get back to first principles—that of keeping the part *clean*, by washing with copious bland fluids, and covering with a neutral dressing which does not stick, and can be removed without trauma to the new epithelium which is trying to grow. It is true that sulphanilamide is added in an attempt to control streptococci, which can be a great nuisance, and sometimes weak hypochlorites are added to the bath, but I cannot say that this appears to have made any noticeable difference.

With the saline method of treatment first and second degree burns heal rapidly and well, and movement is possible from the start. Elevation is very helpful in reducing œdema in the hand (which is an inevitable accompaniment of the burn). In third degree burns it is possible to keep a constant watch on the part and on its bacteriology, and to apply grafts at the earliest possible moment. The enormous granulations which are characteristic of a healing burn in sundry other methods of treatment simply do not occur. In fact, the height of the granulations is in direct proportion to the degree of infection, and as the infection diminishes the granulations become flat and salmon-pink in colour and ready for grafting. At other times parts that seem to require grafting when the patient is first seen heal so rapidly that grafting becomes unnecessary.

The free use of sulphonamide opens up all sorts of interesting questions—the amount of absorption from a raw surface ; the sulphanilamide-resistant organisms, the possibility of creating resistance in a particular organism by continued use ; the sensitisation of the patient to sulphanilamide ; and the sterilisation of the powder itself. I have not time to go into all this, but I mention it to stimulate your interest.

The Bunyan-Stannard method of treatment is more or less a development of the saline method. Bunyan has designed bags of coated silk to fit every part of the body. He himself stresses the beneficial effect of electrolytic sodium hypochlorite, and goes so far as to say that this chemical will sterilise a burnt surface, so much so that preliminary cleansing is unnecessary. I feel that this is rather a dangerous principle to enunciate, but, nevertheless, must agree that the bags are of immense use in any place where a bath is not available, and it is striking how they can be applied to a raw surface, and can be allowed to run on a burnt surface without the patient complaining of pain. It is, therefore, a very useful method when treating tiny children. It also allows of free movement inside the bag, and continuous inspection of the burnt surface, and is said to allow of splinting outside the bag, although I have not used it thus. Remember that the bag is not kept full of fluid, but that fluids are run in at certain stated intervals. I have seen the bag used as a receptacle for pus and have been amazed at the amount of pus that will collect in twenty-four hours, but must add that this is not the author's conception of how the bag should be used. Whether you believe that its good results are due to the hypochlorite or not bothers me little. I personally have little faith in the majority of antiseptics. I prefer to regard it as nothing more than an efficient *cleansing* method.

I have already mentioned the use of sheets of coated silk to wrap round a patient with extensive trunk burns. I am sure that this makes a very excellent medium to place next to the burn, but it naturally has no healing properties, and once again proper *cleansing* is essential.

I have told you that tannic acid has been credited with life-saving properties by virtue of the fact that it is supposed to prevent the external loss of fluid which is supposed to prevent the external loss of fluid which is supposed to be such a big factor in the early stages of the burn, and some also believe that it prevents absorption of toxins (if any) by coagulating everything on the surface. I have for a long time been looking for evidence on the effects of treating a badly burned patient without tannic acid, for at the hospital where I see most of my cases, we have not had a sufficient number of cases within the first few hours to be able to make categorical statements about this very important point. But the evidence seems to have been provided by Koch and Allen, two very well-known workers in Chicago, in their description of the compression method of treatment.

I have on a previous occasion told you how these authors believe in the free use of soap and water in the cleansing of wounds of the hands. They stress once again the danger of using strong chemicals for cleansing burns, and rely entirely on soap and water, and use lard for removing grease. Clothes, if adherent, are soaked off in a bath, after giving morphia. A general anæsthetic should be quite unnecessary and its use

may increase liver damage. All dead skin and blisters are removed. The burnt surface is covered with fine meshed, vaselined gauze, then with fluffed gauze, then with copious dressings of sterile mechanic's waste or marine sponge, and a compression bandage is placed over all. They hold that compression prevents œdema, which is such a bugbear in burns. The parts are placed at rest. In first and second degree burns the dressing is not touched for ten to fourteen days and, when removed, healing is usually complete. In third degree burns measures will have to be taken to get rid of slough, for which they use Dakin's solution. (We sometimes use 1 per cent. trypsin, which, apart from its smell, seems to be useful.) I have seen this method used with striking success in a few cases, and Koch and Allen show pictures of many severe cases that have done well. Grafts are naturally required in total skin loss. But the most startling evidence in their report is the reduction of mortality :—

In	1934-6, using tannic acid alone they had	395	cases with a mortality of	10	per cent.
„	1937, using tannic acid and silver nitrate	82	„	„	„	7.3	„
„	1939, using the pressure method	137	„	„	„	5.8	„
„	1940, „ „ „	164	„	„	„	3.65	„
„	1941, „ „ „	185	„	„	„	2.71	„

I feel that this answers the question of the lifesaving qualities of coagulation therapy.

Finally, a word about plaster-of-paris. Trueta uses it for burns, holding that it, like the compression method, prevents œdema. I have not seen his results, but I can quite believe that they are excellent in minor burns. But I have seen some terrible tragedies in the use of plaster -of-paris in third degree burns. I refer principally to fusion of fingers. It is naturally very dangerous to enclose a hand in plaster if there is the slightest likelihood of the fingers becoming fused. We have occasionally used plaster *to control deformity* in very severe burns that have come to us in terrible positions, but then only for a very limited period of time. It is noteworthy that when the plaster comes off the granulations are usually very high and not in a fit state to receive grafts. Grafts have occasionally been successful in these cases, but it is usually necessary to spend a few days working on the granulations after the removal of plaster. As previously mentioned, plaster is inimical to epithelial growth.

To summarise : If you are at a first-aid post within reach of a good hospital, treat shock, interfere with the burn as little as possible, cover it with a sterile dressing, and send the patient to the hospital. If you are far from a hospital do not do anything that will compromise the work of the people who will see the patient later. Treat shock, give plenty of morphia (gr. 1/3 should be the minimum adult dose), clean the part with soap and water for fifteen to twenty minutes, exposing only a small part at a time, with full aseptic ritual, especially the mask. Apply sulphanilamide powder (sterilised), vaselined gauze, and copious fluffed gauze and wool and a compression bandage (all sterilised) and send the patient off. The patient can safely travel for many days without disturbance of dressings.

If you are in a well-equipped hospital treat shock, give plasma transfusions, clean the part with soap and water under morphia or basal narcosis, apply tannic acid (if you must) to first and second degree areas on flat surfaces, but only sulphanilamide powder and vaselined gauze with moist saline gauze over to the face, hands or flexures, *and to all third degree areas.* Send the patient as soon as possible to a proper burns centre, of which there are many in this country and one or more on all battle fronts. R.A.F. burn casualties have to be notified immediately to the nearest centre, for the R.A.F. are very particular about the methods used on their patients. It is very important to get these patients back to duty as soon as possible, and I may tell you that a very high percentage of all burns cases have returned to full flying duties.

If, for some reason, it is impossible to transfer a patient to a burns centre, the Bunyan-Stannard envelope is a good method of applying the principle of frequent cleansing.

I shall now show you a few pictures of some of the common deformities in burns cases seen at one of the centres. The chief of these are ectropion of the eyelids, which, in the acute stages, may put the cornea in danger of ulceration, ectropion of upper and lower lips, distortion of the nose, distortion of the ears, loss of the eyebrows and eyelashes, and heavy keloidal scars on the face. On the hands heavy keloidal scars are also seen, or merely contraction of the skin on all parts of the hand, severely limiting function ; also tapering of the fingers with loss of subcutaneous tissue, deformities of various types at the metacarpophalangeal joints and the interphalangeal joints, deformity of the nails and in bad cases, fusion of the fingers (syndactyly).

Sometimes the whole hand becomes "frozen" in quite minor burns, from deposition of fibrous tissues in all planes. The question of repair would keep me and you for hours, but I can merely add that it may require many operations and months and months of hospitalisation, tedious for the patient and surgeon alike. Our main task, therefore, is to do all in our power to reduce this.

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Correspondence

NURSES AND THEIR DUTIES.

To the Editor of the GAZETTE.

SIR,—I am what is generally known as a "Guy's nurse"—*i.e.*, a nurse who has nominally done her training at Guy's but really has gained all her experience in the base hospitals, where the shortage of equipment, etc., makes her utilise her brains and draw on her resources for common sense. I read the *Gazette* regularly, but I was grossly insulted by the article on "Front Surgery" by "Auntie Flo." The writer of this article, who is well known to everyone despite his original *nom-de-plume*, should be humiliated by his sense of humour. The instance to which I refer is that of nurses "Type C. Students, for the use of."

I started my training at the beginning of the War because I wanted to be a nurse—not to evade the call-up. I did not come to Guy's to meet men as seems the general case now—especially the type they are now producing. I refuse to submit myself to verify the statement of the "for the use of students."

I am not a prig. I was brought up with a family of boys, and I know what it is to appreciate their company and humour. I have had several "boy friends" and am engaged to a naval officer, whom I met four years ago. I am always *very* glad and take great delight in informing people who enquire that "My *fiancé* is NOT a Guy's man." I have grown lately to loathe all medical students merely because of their insolent attitude to the nurses. I am not alone in my feelings. My friends are all engaged to men in diverse occupations and they all, like me, have "no use" for medical students—at least, the type they coin these days.

I realise that war-time makes an excuse for lowered morals and also that most nurses are as much to blame as the students, but when they refer to them as "for their use" I really wonder what this chaotic world is coming to!

Does the average student, a house man or registrar realise they could not get very far without the nursing staff? If they did, they might learn to respect them a little more and not merely "use" them for their entertainment and pleasure.

I hope, through the medium of your *Gazette*, you will inform the Guy's Medical School that there are still a few decent nurses who appreciate good companionship without coming under "Type C."

Yours, etc.,

A HEAD NURSE.

Guy's Hospital, S.E.1.

CONDUCT OF AN ENGLISHMAN.

To the Editor of the GAZETTE.

SIR,—In one thing Sir Herbert falls short. The simplest rule that governs so much of our conduct as Englishmen begins before the age of five in the home, whether this be in Bermondsey, Battersea, Hampstead or Mayfair; only south of the river we say, "You can't do that there 'ere!

Yours, as a biological Guy's man,

T. B. LAYTON.

Sector News

Guy's Letter

THE Park has taken on a new lease of life as the laying of paving stones over the paths leading to the Medical School and Nurse's Home nears completion. This will be a great improvement on the dust-laden gravel which, in winter, degenerated into so many puddles, necessitating a wide detour or for the more active a running jump.

The children are now settled in the third floor of the Medical Block in Diplock Ward and are getting full advantage of its spaciousness and the balconies. It is altogether a pleasant place for them, and it is no wonder that the American visitors to Guy's, who are so frequent nowadays ,are inevitably taken there.

The Americans, many of them general practitioners but now in uniform, have been a familiar sight during the last few weeks, singly or in parties, and Dr. Bishop and other members of the staff have been entertaining them and taking them round the Hospital. Guy's, as a "front line" hospital of the "blitz," has much to show quite apart from the antiquities in which the Americans are so keenly interested. The names of Addison and Bright may be well enough known to the man from a university across the Atlantic, but that Guy's is the centre in which they worked impresses him with particular force when he is here to see it.

We congratulate Gardner on his recent marriage and our best wishes for the future go with him. Tom Collins, the Dental H.S., has also left the residents and is to take an appointment as demonstrator in the Dental School; in his place we welcome E. A. Glover.

Since the last letter there have been two or three dances in the Nurses' Home, one in aid of a hospital at Stalingrad organised by the theatre staff, which raised some £15.

R. I. M.

Orpington Letter

A. J. CRONIN'S "Jupiter Laughs" was presented by medical students and nurses at Orpington Hospital last week, and each of the three performances was received by the audiences, which included Miss MacManus at the final performance, with the interest and enthusiasm it so rightly deserved.

The Players.—Dr. Venner, close on the discovery of something big; hard bitten, riding rough-shod over the feelings of all, and waging perpetual war with Matron, was admirably played by Paul New.

Nurse Marjorie Emslie, as Matron, was outstanding. She acted with admirable restraint and a fine economy of movement. This was a very good portrayal of a difficult character.

Nurse Margaret MacNab, as Dr. Mary Murray, was natural, showed good stage presence, and tackled her emotional scenes with considerable ease. Perhaps a little more fervour would have been in keeping with her religious outlook.

Mrs. Bragg, played by Nurse Mary Rivers, formed, with Dr. Venner and Dr. Murray, the other point of the eternal struggle. This is not an easy part and Nurse Rivers did very well with it.

The two colleagues of Venner, Dr. Drewett and Dr. Thorogood, were played as John Humbley and Nigel Nicholson. Both gave us some good acting.

Alan Cashmore took the part of Dr. Bragg, the Medical Superintendent, a study in self-satisfaction and pomposity. His intonation, movements and expression were good, but we were not convinced that he was as old as he was meant to be.

The two smaller parts of Albert Chivers and Jenny were played by Rimmer Lee and Nurse Mary Baker respectively. To these was entrusted the legitimate humour of the piece, and it proved to be in capable hands.

The stage manager, R. G. Walton, had a difficult job and went a long way on very little. When realism failed him he fell back on impressionism and produced a wonderful and tasteful lighting.

At each performance a collection was taken in aid of Guy's Rebuilding Fund.

DRAMATIC CRITIC, Orpington.

Sport

Cricket

The match (12 a-side) against Old Rutlishians on July 4th at Merton ended in a draw. Guy's, 262 (Sheerboon 66, Saunders 58); Old Rutlishians, 168 for 10 wickets (Murphy, 5 for 24; Brangwin, 5 for 42). The Guy's total of 262 was rather flattering to the batsmen on this occasion. A combination of short boundaries and a tantalisingly uneven outfield made the score mount rapidly, and the runs were made in two and a quarter hours. After losing three quick wickets Ricketts and Bushby put on 125 for the Old Rutlishians, and when the latter was out thirty minutes were left for Guy's to get 7 wickets. Suffice it to say that the last batsman successfully stopped his one and only ball which was the last of the match. Perhaps Guy's would have done better to declare. Surely we would have won had a vital catch been held, but post-mortem speculations are always distasteful and rarely profitable.

Team.—E. G. Murphy, D. C. Boyd, G. Thompson, D. R. S. Saunders, A. Brown, R. G. L. Brittain, D. Nicholson, D. J. Sheerboon, R. Finney, P. L. Brangwin, A. E. Trist, J. Elder.

On July 11th at Imber Court Guy's, against Metropolitan Police, lost by 45 runs. Metropolitan Police, 173 for seven (declared); Guy's, 127.

Sunday afternoon must follow closely upon Saturday night—only too closely in some cases—and it was particularly unfortunate that we should have arranged to play such a sober and experienced side as the Metropolitan Police following an evening which, near enough, coincided with the end of the Conjoint Final examination. It was also unfortunate that Clarke should have divulged his wiles to the same team only the week before when playing for the Empire XI. Finally, the day was cold, windy and damp, with the result that our fielding was painfully disinterested—in spite of an undefeated record to defend.

We were left two and a quarter hours to score 174—by no means an impossible task. Several batsmen batted confidently and well, only to be out in some rather trivial way, and by dint of steady bowling and excellent fielding the wickets gradually fell—our last man being out with half-an-hour to spare.

Team.—E. W. R. Alderman, E. G. Murphy, C. B. Clarke, G. W. Garland, G. Thompson, D. R. S. Saunders, D. T. Sheerboon, L. D. Carton-Kelly, R. G. L. Brittain, A. Brown, D. Nicholson.

Against N.F.S. (London) at H.O.P. on July 17th, Guy's lost by six wickets. Guy's, 100 (Saunders, 30); N.F.S., 133 for eight.

Guy's loss the toss and were rather surprised to be sent in to bat on what appeared to be a perfect batsman's wicket; but in war-time cricket the use of the single new ball is an extra consideration and, in this case, the Fire Services captain seemed fully justified when we were all out for 100. Our batting was very subdued and the policy of waiting for the loose ones was useless, as they just never came. At tea our morale sank even lower under the influence of accounts of the large scores made by our opponents recently. However, Alderman was not to be disheartened and convincingly bowled two reputable bats in his first over. Guise was dropped in the slips off him shortly afterwards and proceeded to make full use of his "life" to produce a truly masterly 57. So we lost by six wickets and came away feeling well defeated with not an "if" to our name—which is unusual in cricket!

Team.—E. W. R. Alderman, G. W. Garland, E. G. Murphy, D. C. Boyd, C. B. Clarke, G. Thompson, D. J. Sheerboon, L. D. Carton-Kelly, D. R. S. Saunders, R. G. L. Brittain, A. N. Other.

Hospital Information, etc.

Pass List

UNIVERSITY OF OXFORD

2ND B.M. EXAMINATION

June, 1943

Pharmacology and Principles of Therapeutics

J. D. L. Reinhold

Papers by Guy's Men

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EDS. { J.O.L. R.R.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE last few weeks have seen two new landmarks established in the history of the Royal College of Surgeons. Firstly, the Fellowship has reached its centenary; and, secondly, the new rules for the Primary and Final have been issued. Of the first we need say no more than congratulations, for there is no occasion to expiate on the virtue, both academic and practical, of so famous an examination.

The changes in the rules, however, are likely to cause some discussion. Briefly, the new regulations introduce two changes—that in future the Primary is to be taken only by those already medically qualified, and that there is to be a two-year period of surgical practice in a recognised hospital between qualification and the Final examination. Both these provisions must cause considerable change in our arrangements. At present budding surgeons have been in the habit of putting in an extra period of anatomy after the second examination and getting their primary while anatomy and physiology were fresh in their minds—only to find it had mostly escaped them again by the end of their subsequent three years of clinical study. Now there will be no pause before entering the wards; it must come afterwards—together with the two years of surgery now required. Such a change can but be welcome to those who have urged the closer association of surgery with both anatomy and physiology, and this period should be most valuable to the surgeon.

It will, however, mean an alteration of the present system of appointments if the best advantage is to be gained. The ideal would appear to be a composite post of registrar-*cum*-demonstrator type to follow house jobs. In this the surgeon, although being allowed to gain his operating and general surgical experience as the registrar is at present, should nevertheless be given the time and opportunity to restudy his anatomy and physiology from his new viewpoint concurrently with his surgery. If every man is to have the chance which his merits deserve, these jobs, it goes without saying, must be adequately paid—the fact that he is still learning is no excuse for underpaying a man for the work he does. This, which applies to all jobs, is by no means accepted to-day as is evident enough to the newly qualified man, but it must be taken as the basis of any future medical service, State or otherwise, if we are to get the maximum out of our doctors. The example the Royal College of Surgeons have shown in altering their regulations so radically at the present time will, we hope, not be lost on other examining bodies. Although they come into force at the end of this year, the regulations are obviously framed with a view to the post-war years as war-time conditions will not allow of their fulfilment at present. As it is everyone now has a breathing space in which to alter conditions to fit them and to fit in such altered prospects with schemes of post-War planning.

Whether a State medical service will be accompanied by a State final examination is a point which does not appear to have been considered very earnestly as yet. Some uniformity is, perhaps, desirable, but it is certain that the present examining authorities would not easily give up their own exams.—and, indeed, there is no reason that they should. A State examination could run in parallel with the Univeristy ones as the Conjoint now does, but whether any advantage would accrue is a point which merits consideration.

WE must offer congratulations on behalf of all Guy's men and women to Captain C. P. Blacker, M.C., R.A.M.C., on his being awarded the George Medal for great gallantry in North Africa. Captain Blacker went into a minefield in which two men had just been killed and, although he did not know the disposition of the mines, he was able to reach a wounded officer and bring him to safety.

Experimental Studies on Leukæmia and Allied Conditions

By P. A. GORER, D.Sc., M.R.C.S., L.R.C.P.,

Department of Pathology, Guy's Hospital Medical School.

INTRODUCTION.

BEFORE proceeding to the main discussion it will be as well to clarify certain points in connection with the terminology to be employed. Most people are agreed that there is a close relationship between leukæmia, aleukæmic leukæmia, lympho-sarcoma, myelomata, etc. The last-named conditions in their turn merge into the group of neoplasms known as reticulo-sarcomata. Some pathologists group the whole under one heading as reticuloses. The present article is concerned in the main with conditions more or less closely related to leukæmia and the term *leukosis* will be used to include leukæmias, aleukæmic leukæmia, lympho-sarcomata, etc.

Leukoses are certainly far from rare in several species of lower animals; little is to be gained by giving a list of the species in which they have been recorded, the great bulk of experimental work having been done on fowls or mice. Amongst the former this group of diseases is so common that its study would be of importance to poultry-breeders quite apart from its interest to medical science.

LEUKOSES IN FOWLS.

(*a*) *Pathology.*

Three distinct types of leukoses are described in fowls—lymphatic, myelogenous and erythro-leukæmic. The two former are recognisably similar to the corresponding conditions in man. The last may be related to polycythæmia rubra, but the differences in hæmopoiesis in birds and mammals make any close comparison difficult. Polycythæmia always runs a more or less chronic course, whilst erythro-leukæmia may be acute or chronic. The acute cases are characterised by anæmia and the presence of numerous basophil erythroblasts in the circulation. In the chronic cases red cells in various stages of maturity may be found. Sometimes one meets with cases in which the blood picture shows the presence of immature myeloid cells and immature erythrocytes. Human polycythæmia sometimes terminates as a myelogenous leukæmia and occasionally the blood picture may show features of both conditions simultaneously, in which case the condition is called erythro-leukæmia.

The pathology of myelogenous leukoses does not demand further description here. The lymphatic leukoses are the most commonly occurring and usually take the form of an aleukæmic leukæmia. The well-known and economically important condition of fowl paralysis or neurolymphomatosis shows certain affinities with the typical leukoses. The morbid anatomy of this condition is subject to considerable variation. Typically there are nodular accumulations of lymphocytes along the nerve trunks. In other cases there is considerable visceral involvement and the similarity with true lymphatic leukoses is close. However, fowl paralysis tends to occur at an earlier age than lymphatic leukosis, and the former is said never to involve the bone marrow, whilst the latter usually does so. Further reference to this subject will be made below.

THE TRANSMISSION OF FOWL LEUKOSES.

As long ago as 1908 two Danish scientists, Ellerman and Bang, showed that leukæmia might be transferred to healthy fowls by means of tissue suspensions or cell-free extracts of affected organs. At that time the differentiation of the various types of fowl leukoses had not been clearly made; it is now thought that only myelogenous leukæmia and erythroleukæmia are transmissible. Transmission by cellular suspensions may mean that an infective agent is released from the inoculated cells (as might happen if we inoculated gonococcal pus) or that the inoculated cells have proliferated to produce the disease. The fact that cells are not necessary shows that an infective agent is effective for the purpose. In short, erythroleukæmia and myelogenous leukæmia must be classified as virus diseases. The virus may be obtained from plasma as well as from various organs, and Dr. Furth, of New York, has shown that one millionth of a c.c. may produce the disease.

Spontaneous leukoses are commonest in birds over nine months of age and tend to occur most commonly in the late winter and early spring. Transmission is most often successful with young chicks and during the late spring and early summer. The reason for this seasonal variation is far from clear and several different theories have been put forward. It is possible that many older birds have acquired an active resistance to the virus whilst younger ones have not done so. Young birds may sometimes survive the inoculation of the virus with or without showing signs of the disease. If they do so they are generally resistant to subsequent inoculation.

The fact that these fowl leukoses are attributable to a virus is quoted by some pathologists as evidence that human leukæmia is " infective " and not " neoplastic." It will be recalled that in 1910 Peyton Rous showed that a fowl sarcoma was due to a virus. Since this time " virus " tumours have been shown to occur in ducks and over twenty more have been demonstrated in fowls. Since 1933 workers in Paris, New York and Copenhagen have shown that a close relationship exists between the viruses concerned in leukæmia and sarcomata of various types. It is impossible to do justice to the workers concerned within the space available. Briefly, it appears that certain strains of virus may give rise to leukæmia and sarcomata especially if the fixed tissues are injured during injection ; under other conditions leukæmia alone results. There is convincing evidence that this is not due to accidental contamination with a " sarcoma " virus. The types of sarcomata concerned vary in structure. Some are spindle-celled ; others are endotheliomatous or angio-sarcomatous. Similar conditions may perhaps occur in man. For example, a patient was found to have a somewhat atypical leukæmia in which eosinophils predominated. The superficial lymph nodes were enlarged and histologically showed a malignant reticulosis ; so far as I know at present his condition has improved as a result of deep X-ray therapy.

The study of neuro-lymphomatosis raises many points of interest. At one time there was considerable controversy whether the disease was " hereditary " or " infective " in origin. Blakemore, working in this country, has shown that both factors are involved. Strains of fowls vary greatly in their inherent resistance and since the disease is very widespread it usually happens that genetically a susceptible strain will have a high proportion of birds that have been infected spontaneously, with the consequence that the interpretation of inoculation experiments is very difficult, whilst resistant strains will obviously give negative results. By rearing a susceptible strain under very carefully controlled conditions, Blakemore was able to show conclusively that a virus was concerned. As has been mentioned previously the morbid anatomy and histology may vary considerably from a condition almost, if not quite indistinguishable from a lympho-sarcoma, to one that is more suggestive of an inflammatory lesion. In Blakemore's highly susceptible strain, frankly, inflammatory lesions occurred. The disease thus occupies an intermediate position between a neoplasm and a granuloma. It may well be that Hodgkin's disease is somewhat similar, but in this case the condition begins as a granuloma and evolves into a neoplasm. Experiments with certain viruses in the rabbit lend further support to the view that this is quite possible.

LEUKOSES IN MICE.

Pathology.

Leukoses of various types are relatively common in mice. At the present time most research workers make use of strains of mice that have been rendered genetically homogeneous by continued brother-sister inbreeding. The susceptibility of different pure lines varies very widely ; one is known where 90 per cent. of mice aged over six months die of leukoses ; in others the figure is 70 per cent., 50 per cent., etc. It is doubtful if any pure line is entirely free from the disease, although the incidence may be only 1 or 2 per cent. Lymphatic, myelogenous and monocytic leukæmias have been described, as have lympho-sarcomata, myelomata and chloromata. By and large, lymphatic leukoses are the commonest, but this again varies with the strain of mice. In my own strains acute leukæmias (probably myeloblastic) appear to be the commonest type apart from lympho-sarcomata. Chronic cases do occur as well and, anatomically, are very similar to the condition in man.

THE TRANSMISSION OF MOUSE LEUKOSES.

Up to date nobody has succeeded in transmitting leukæmia to healthy mice in the absence of living cells. Under suitable conditions the inoculated cells proliferate to produce the disease. Three sets of conditions are of importance in determining the

outcome of inoculation—(1) The presence or absence of antigenic differences between the inoculated tissue and the host; (2) the route of inoculation; (3) the number of cells inoculated.

The genetical laws governing the transmission of the leukoses are the same as those concerned with other types of normal and neoplastic tissues. It would appear that the situation is analogous to that obtaining with blood transfusion, although there are differences in detail. Instead of four distinct groups we have to deal with some thousands of different antigenic types; the presence of individual antigens being determined by dominant genes. The result is that transmission experiments are only reliable when pure lines are used. Transmission within a given line usually succeeds; when attempted between different lines a negative result is to be expected, as is the case with ordinary mixed stocks. Even if success is obtained under the latter conditions, the pathological picture may vary greatly from case to case and the results are too complex to be interpreted. The information that follows was all obtained from experiments with pure lines.

Transmission is more likely to be obtained following intravenous inoculation than if the intraperitoneal or subcutaneous route is used. In many cases all three routes give successful results, and the last has given much interesting information. The dose depends to some extent on the route of inoculation, but varies enormously from case to case. Furth and Kahn had a case of monocytic leukæmia in which a single cell was sufficient for transmission. Other observers have dealt with cases in which the number is less than one hundred, but it may happen that a million are necessary. I have the impression that some cases are not transmissable although typical clinically. It is, of course, difficult to be sure that failure is not due to some technical defect.

If a number of different cases are transmitted within the same pure line, it is found that the morbid anatomy may vary greatly even if cases of very similar histological appearance are used. Thus with acute leukæmias one may find that some stimulate ascites and give enormously enlarged livers; others are typified by enormously enlarged lymph nodes and spleen; others may give an early involvement of the nervous system, etc. The only possible explanation is that the metabolic requirements of the cells from different cases facilitates their development in different organs. This should be borne in mind when considering the various highly complex theories that have been put forward to account for the distribution of metastases in the human body.

It is sometimes argued that human leukæmia is not neoplastic because the lesions are diffuse and there is no primary focus such as can usually be identified in the case of respectable neoplasms. Transmission experiments suggest very strongly that this argument is without much weight. Even if leukæmic cells are inoculated subcutaneously it may be impossible to identify the site of inoculation with the naked eye. If one knows where to look, one may be able to find it histologically, but without prior knowledge one could not do so.

As might be expected, transmission experiments show that there is no hard-and-fast line between typical leukæmias and lympho-sarcomata. Furth had a case in which subcutaneous inoculation gave rise to lympho-sarcoma and intravenous inoculation to leukæmia. I had a case that started out as a fairly respectable lympho-sarcoma, but turned into leukæmia after some passages. Most workers can confirm such results as these.

THE ÆTIOLOGY OF MOUSE LEUKÆMIA.

Information obtained from Genetics.

As has been said above, no evidence for the presence of a virus has been obtained with ordinary transmission experiments and the same applies to other murine neoplasms. However, such evidence has been obtained from genetical experiments with leukæmia and with mammary cancer. In neither cases does the spontaneous disease show simple Mendelian inheritance. If two contrasting strains are crossed, the hybrids resemble the maternal parent. A long series of experiments have made it fairly certain that, in the case of mammary cancer, a virus is passed in part in utero and in part in the milk. Some strains of mice are resistant to the virus even if they are suckled by a female that is known to pass it in her milk. The virus will only produce cancer in a breast that has matured under the influence of œstrogenic hormones. In the case of leukoses the results are similar in general outline, but less clear cut. It would appear that we are likely to be facing the same kind of difficulties that obtained with neuro-lymphomatosis, but the situation is apparently still more complicated. Some work done by MacDowell and his colleagues suggests that certain strains of mice

may be " carriers "—that is to say, the incidence of leukæmia in such strains is not high, but they appear to carry an agent that is effective when passed to mice of a suitable genetical constitution.

INFORMATION OBTAINED FROM THE EMPLOYMENT OF PHYSICAL AND CHEMICAL AGENTS.

In the case of human leukæmia it is stated that prolonged exposure to X-rays and to benzol may be causative factors. Experimental work has shown that the former are effective in mice whilst the latter is of somewhat doubtful significance.

It is well known that tar can produce cancer of the skin in man and a number of lower animals, of which mice are the most studied. Tar has given rise to leukæmia in fowls when applied to the marrow and in mice following cutaneous application. Tar contains the hydrocarbon benzpyrene, which is an active carcinogenic agent. However, since different samples of tar vary in effectiveness, nowadays most people use one of the numerous hydrocarbons that are available. The results obtained depend in part upon the technique, but, to a very large extent, upon the strain of mice used.

If a strain with a high " spontaneous " incidence is painted, leukoses may occur very much earlier than in controls. However, a very high percentage of leukoses may be obtained very rapidly in certain strains of mice in which the spontaneous disease is not particularly common. To complicate the matter still further a strain of mice is known in which œstrin is effective, whilst hydrocarbons, potent in other strains, are not.

These results are very difficult to interpret. Briefly, it would appear that we must consider two possibilities. It may be that chemical or physical agents modify the tissues so that a latent virus becomes active ; on the other hand, it is perfectly possible chemicals such as the hydrocarbons, etc., are able to produce the same alterations in cellular behaviour as are viruses. Speculations on this point are fascinating and valuable in so far as they help to suggest fresh lines of investigation or observation. However, the matter will not be settled by argument, however profound these may be, and it will probably be some time before a final decision can be reached.

A COMPARISON OF THE LEUKOSES IN ANIMALS AND MAN.

There are two common errors in comparative pathology. One may glibly assume that what applies to one species applies to all, or one may content oneself with the profound remark that mice are not men. The latter view has certain advantages. It saves a good deal of reading and protects the mind from subversive views that might threaten one's most cherished theories.

It is quite clear that the leukoses in fowls and in mice must be classified as neoplastic diseases. Furthermore, experimental work has shown that the morbid anatomy of leukæmia can no longer be put forward as an argument that this is not so in man. However, this does not settle the matter entirely. In all three species under consideration certain conditions may resemble leukæmia very closely and there are a certain number of cases in which the diagnosis remains in doubt even after autopsy, although it is usually possible to find some source of infection or other cause for the condition. Israels has suggested that the so-called leukæmic states in the lower animals do not correspond to leukæmia in man. His arguments are based largely upon the results of tissue culture. He found that primitive cells from acute myeloid and monocytic leukæmia tended to mature in culture, whilst most of the published results of cultures of mouse leukæmias gave an entirely different picture. It is necessary to bear in mind several points in assessing the value of his observations. In the first place most of the murine leukæmias have been lymphatic in type. Furthermore, most of those that have been studied in culture are those that have been transplanted a number of times. There can be little doubt that in all transplanted neoplasms there is a very intense cellular selection. The original growth, consisting of a mixture of cells varying considerably in their rates of growth and differentiation ; during transplantation the most rapidly growing types tend to supplant the others, the final result being a fairly homogeneous population of cells. Furthermore, the maintenance of leukæmic cells in culture is a very tricky business and the results vary considerably with the technique employed. Certain experiments with mouse leukæmias have given the same results as those obtained by Israels. In tissue culture it seems that selection operates in an opposite direction to that obtaining during transplantation, the most malignant types tending to die out. Lastly, it is

necessary to emphasise that differentiation may occur with malignant cells as is shown most strikingly in squamous celled carcinomas.

Another fact urged against the neoplastic nature of human leukæmia is the occurrence of spontaneous remissions. However, these have occurred in virus induced leukæmias in the fowl and possibly in mice as well. In any case analogous phenomena may occur with other types of neoplasm. The following experience of my own with a chemically induced cutaneous tumour in a mouse will demonstrate this point. Last June a small wart was noticed which grew slowly for about three months and then stopped. By the beginning of this year it was actually becoming smaller, and had almost disappeared by the beginning of March. However, in April, it began to grow very rapidly, and by the end of May the animal was killed with a huge fungating carcinoma.

Even if one does not accept Israel's views, one should recognise the value of his contribution. Tissue culture offers one of the only methods by which human and animal leukæmic cells can be compared. It is clearly desirable that both human and mouse leukæmias should be compared in culture far more thoroughly than has been done hitherto.

Unfortunately, the experimental pathologist has but little to suggest so far as treatment is concerned. Progress is likely to be more rapid if clinicians and experimentalists know what one another are doing than if each continue to work apart. It is hoped that this article may suggest further lines of investigation to the former.

REFERENCES.

The literature up to 1940 is reviewed by J. Engelbreth-Holm in his book, "Spontaneous and Experimental Leukæmia in Animals," published by Oliver and Boyd. Most of the work since then has appeared in the journals, *Cancer Research* and the *Journal of the National Institute of Cancer.*

Correspondence

"REBUILDING BRITAIN."

To the Editor of the GAZETTE.

SIR,—*The Times Literary Supplement* for May 15th has just reached me here. In it there is a review of a book, "Rebuilding Britain," written for the Royal Institute of British Architects. There is a quotation cited which is so appropriate as a postscript to a letter I wrote to you, now nearly two years ago, on the subject of rebuilding Guy's that I thought your readers might like to have it brought to their notice. "For we can be sure that any plan that does not raise a certain amount of hostility, and disturb a number of sentimentalists, will be recognised as the timid, fiddling thing it is by the future generation who will have to suffer from it."

Yours, etc.,

H. J. B. ATKINS, Lieut.-Col., R.A.M.C., B.N.A.F.

NURSES AND THEIR DUTIES.

A number of letters have been received in reply to "A Head Nurse," and the following are fair examples. We feel sure that the original letter was not intended to be taken too seriously and that good relations continue between staff, nurses and students—as, indeed, they always have done at Guy's. In conclusion, space is short and we would prefer to consider the matter closed—after this brief, but, we hope, beneficial, "airing."—EDITOR.

To the Editor of the GAZETTE.

SIR,—May I be permitted to make brief reply to the lady who writes in your current issue under the inapt heading, "Nurses and their Duties"? As I read this letter yet again I realise that I am prompted to reply by one statement and one only. That statement is, "I have grown lately to loathe all medical students merely because of their insolent attitude to the nurses." Brevity bids me make no comment on other matters—social and moral—raised in this letter, but I feel that such a spear of loathing should not be cast without retaliation.

I know that I am not alone among students in this Hospital in my appreciation of the untiring work of the nursing profession and in my admiration of the way they carry out their exacting tasks—tasks for which the rewards are in many ways inadequate. I am troubled, therefore, by the accusation of insolence which has been levelled at the students in this Hospital. During the brief association which I have so far had the honour to make with the nursing staff, no attitude has been further from my mind and, I am certain, from the minds of all my colleagues, both senior and contemporary. I cannot but feel that so many are being condemned for the shortcomings of the so thoughtless few.

I hope that the lady writes in the heat of a moment. If not and if this is really the considered attitude of a responsible member of the staff of the Hospital—an attitude which, we are told, is shared by others—what augury is this for the preservation of that spirit and tradition of Guy's of which you, Mr. Editor, have written this very week, and of which so many who contribute to your pages are proud—and rightly proud ?

Yours, etc.,

IAN A. H. MUNRO.

Guy's Hospital, S.E.1.

To the Editor of the GAZETTE.

SIR,—Speaking as some of the "insolent" and, apparently, lascivious, students who came to Guy's before the War to study medicine, and not to avoid the call-up, we consider that the letter by your correspondent, "Head Nurse," is in singularly bad taste and that the wording is extremely ill chosen. Were it not for the fact that the *Guy's Hospital Gazette* is a serious journal read throughout the medical world, we should be tempted to dismiss the letter as an hysterical and irresponsible outburst. As the matter stands, if it be taken seriously, the impression will be spread abroad that Guy's can no longer be respected as one of the major teaching hospitals in the country.

Having all worked in close contact with the nursing staff for the last three years, we are acutely conscious of the fine and indispensable work they perform in the wards. We shall not deny that we have all enjoyed the good companionship of nurses, but we have always been led to believe that the pleasure was mutual. If, however, this was not the case, then we are all greatly indebted to the nursing staff for their tolerance and forbearance.

It seems regrettable that your correspondent finds it necessary to insult the staff and nurses, as well as the students. We hope that, in the future, she will not use the columns of the *Gazette* for such libellous, seditious and anonymous generalisations.

Yours, etc.,

R. FINNEY, G. W. GARLAND,
P. G. LARGE, A. B. LEE,
JOHN K. MORGAN, W. H. SMITH,
J. R. TROUNCE.

STATE REGISTERED DENTAL NURSES.

To the Editor of the GAZETTE.

SIR,—Guy's has always been a pioneer in dental matters and our Dental School is probably the biggest and certainly the most famous in this country. It would, therefore, be fitting that they should break new ground and institute a training school for dental nurses. At present there are many hundreds of dental nurses working all over the country, most of whom have had to rely upon their principals for training. A definite profession has thus grown up of nurses specially skilled in dental work whose title as "Nurse" is merely complimentary.

May I put forward the suggestion that the institution of State Registered *status* is long overdue; that a syllabus of training should be drawn up; and a Register of Dental Nurses should be introduced with as little delay as possible.

I hope your readers will voice their opinions.

Yours, etc.,

"STANLEY."

"Jacobsoniana"

Many tales in "Jacobsoniana" are likely to contain references to cigars. One evening, after he had completed some of his marvellous coloured drawings on the blackboard for the next day's anatomy lecture, he said to the porter: "A package containing a box of cigars will be delivered here for me. Directly it comes, bring it to my house."

The package duly arrived and the porter took it to Pom's house near Hyde Park. As he often did, Pom opened the door and the porter handed the box of cigars to him.

"Do you like cigars?" asked Pom.

"Yes, sir, thank you, sir," replied the porter, expectantly.

"Well, you won't like these. These are cheroots!"—and closed the door.

"When you get into practice," Pom told one of his dressers, "there are two classes of people whom you can 'bleed' without compunction—the publican and the country attorney. Both of them are beasts of prey."

Jacobson had nearly finished taking out-patients in the old out-patient surgery, into which there were two doors, one leading into a long paved passage. A dresser from another firm came in through the latter door with a message to Jacobson from another surgeon. Seeing only a few patients, two or three dressers and the H.S., he said in a loud voice: "Is that d——d old fool Jacobson here?" For a few seconds there was a death-like silence and then a chair behind a screen scraped on the floor. Jacobson climbed on to the chair and, putting his white head over the screen, said: "That d——d old fool Jacobson is here." Almost before he had finished speaking the dresser's feet could be heard running down the passage at great speed. He did not deliver his message.

On certain Wednesday afternoons Jacobson used to bring old patients into the old operating theatre, which had tiers of seats running round it. Usually a large crowd attended the demonstrations and Jacobson asked questions rapidly, directing his finger at different members of the audience and saying, "You—you." On one occasion he exhibited a boy with a stiff knee, which had a small round scar on each side and asked several what the condition had been, without getting a satisfactory answer. He then pointed to the writer, who said: "It was obviously a septic knee." Jacobson jumped and shouted: "Obviously, sir—obviously! Nothing on God's earth is obvious. This might have resulted from a bullet wound, a perforation by a pitch-fork, or half-a-dozen other things, but it is true that it was a septic knee." The writer (and probably several of those present) has never forgotten the lesson and recollects it every time he sees the word misused in a paper.

On another occasion Jacobson noticed a tall, well-built student taking notes at such a demonstration on the backs of old envelopes and inquired if he thought this a proper method of taking notes. The student replied that he afterwards copied them into his note-book. Jacobson looked at him for a short time and then said: "Very nicely said, sir"; and, with a smiling face, "but you are a d——d liar!" When the student came to the next demonstration he realised that he had forgotten to obtain the mythical note-book and asked a friend to lend him one, which happened to contain notes on midwifery lectures. Soon after he came in Jacobson noticed the student and demanded to see his note-book, which was handed to him with great reluctance. Jacobson looked at the illustrations and then in silence held up a page with a particularly gaudy illustration for all to see. He then returned the book and remarked: "My diagnosis last time was correct."

At the commencement of a new period Jacobson walked into the Colonnade, where his H.S. introduced his new dressers to him. He looked briefly at each and then said: "God knows what fools you are, I don't!"

Reviews

A Complete Handbook of Hygiene in Questions and Answers. By EVELYN PEARCE. Published by Faber & Faber. *Price* 3*s.* 6*d.*

THIS book is well known by most student nurses and is useful for revision to candidates who are preparing for the preliminary State examination. As stated in the preface it is not intended to be a complete text-book of the subject, and nurses will need more comprehensive works in order to gain a wide and practical knowledge of hygiene. F. T.

First Aid. By J. F. SUTHERLAND. Published by E. & S. Livingstone. *Price* 9*d.*

A CURIOUS little book which appears rather to fall between two stools. It is inadequate for the professional first-aid worker and the terminology is too professional for the lay-man. It is designed to be carried in the waistcoat pocket. This may be useful if one is studying for an examination, but it is questionable whether or not it would be so to the layman suddenly confronted with a choking child. However, in many ways, it is a good ninepenny worth. F. T.

Fevers and Fever Nursing. By EVELYN PEARCE. Published by Faber & Faber. *Price* 6*s.*

A NEW edition of this book is particularly welcome at the present time owing to the special care necessary to prevent the spread of infection under war-time conditions. New information on bacillary dysentery, undulant fever, glandular fever, typhus fever, trench fever and epidemic relapsing fever is included in this edition. There is also a new chapter on infective jaundice. More details concerning the prevention of spread of pulmonary tuberculosis would have been welcome, such as the treatment of sputum. "A cuspidor in the form of a destructible carton" is not always obtainable, nor is it universally accepted as the most desirable type. The few charts and diagrams add to the interest of the book. There is also a useful collection of examination questions at the end. F. T.

Sport

Cricket

Guy's beat St. Bartholomew's Hospital by 58 runs at H.O.P. on Saturday, July 24th.

It was Saunders's match. Of the Guy's total of 124 he scored 39, and by getting five wickets for 18 runs he played a big part in dismissing Bart's for 66. Murphy also bowled well to get four wickets for 32 runs.

Team.—E. W. R. Alderman, G. W. Garland, E. G. Murphy, D. C. Boyd, D. R. S. Saunders, L. D. Carton-Kelly, G. Thompson, R. Finney, R. G. L. Brittain, J. Robb, P. L. Brangwin.

On Sunday, July 25th, at H.O.P. Guy's beat Buccaneers by three wickets.

Buccaneers batted first and very surprisingly lost six wickets for 39 runs. A bright stand then followed which made their total a little more respectable, but even so they were all out for 97. Guy's fielding was good; *Sheerboom, especially, ran out their opening* batsman from cover-point. Guy's started well and the opening partnership yielded 42 runs, but then, as so often happens, there was a collapse, and seven wickets were down for 72 runs. Boyd and Brittain came together, however, and won the game with a stand of 97 runs. Brittain, forcing the pace well, scored 53, and Boyd was unbeaten with 49, when the game ended. Guy's total was 169 for eight wickets.

Team.—E. W. R. Alderman, G. W. Garland, E. G. Murphy, D. C. Boyd, D. R. S. Saunders, C. B. Clarke, L. D. Carton-Kelly, D. J. Sheerboom, P. L. Brangwin, R. G. L. Brittain, J. Elder.

Rowing

The annual hospitals regatta was held at Putney on June 26th. Owing to war-time conditions the formation of crews had been difficult, training was curtailed and Guy's did very well to reach the finals in all the events they entered and to win one.

In the senior eights Guy's met Westminster and, although slow off the mark, the crew soon settled down and won by two lengths. Guy's met St. Mary's in the finals; the latter took the lead and, in spite of numerous sports, Guy's were unable to reduce the lead and lost by two lengths.

Crew.—Bow, P. A. W. Lea; (2) P. F. Pearson; (3) C. W. Williams; (4) D. J. Chapman; (5) J. C. Bayliss; (6) T. Timms (7) M. D. Cremin (captain); stroke, R. T. Lowein; cox, A. W. Fookes.

In the heats of the coxwainless fours Guy's met Westminster and won easily. Guy's had a hard fight with St. Mary's in the finals, but after the halfway mark St. Mark's drew away and won by a length.

Crew.—Bow and steers, P. A. W. Lea; 2, T. Timms; 3, M. D. Cremin (captain); stroke, R. T. Lowein.

In the senior sculls Lowein easily beat Morton, of Westminster.

The Rugger fours were a source of great amusement to everyone. Messrs. Lee, Micklem, Earle and Lewis reached the finals and were were level with St. Mary's until one of the Guy's crew pulled his rigger off!

Hospital Information, etc.

Pass List

CONJOINT BOARD.

July, 1943.

Surgery.

R. R. Burn	H. J. Lewis
A. G. Ellerker	S. A. Marsh
J. M. Fabricius	J. W. Robb
*M. M. Figgis	W. H. Smith
*M. A. Filose	J. R. Trounce
A. E. Gibbs	G. M. Turner
*C. W. L. Jeanes	*R. Webb
P. G. Large	

Midwifery.

R. A. Allen	*P. Hopkins
D. H. Broughton	M. D. Keates
M. J. Cutler	S. A. Marsh
J. Fry	P. F. Pearson
*C. O. Fung-Kee-Fung	D. Rosenberg
*R. L. A. Gouges-D'Agincourt	*R. Webb
	C. F. Ziervogel

Medicine.

*J. K. Argo	*H. P. Merrick
D. H. Broughton	D. Rosenberg
*M. A. Filose	*K. H. L. Scougall
*W. Fox	C. L. E. H. Sharp
*G. Hildick-Smith	*R. S. Smith
T. Koonvisal	*R. M. Woodside
*H. J. Lewis	

Pathology.

F. J. Aumonier	J. L. F. Maine
A. Brown	J. K. Morgan
A. B. Dickie	D. Rosenberg
M. E. Evans	C. L. E. H. Sharp
*W. Fox	W. H. Smith
J. Fry	J. R. Trounce
A. E. Gibbs	A. B. Vanscolina
P. G. Large	D. P. Wheatley
N. L. M. MacManus	

* Has now completed the examination.

CONJOINT BOARD.

FIRST EXAMINATION.

June, 1943.

Anatomy.

G. F. Barnes.	J. K. Grieves.
A. G. Bearn.	C. D. Korn.
W. M. Dixon.	R. H. N. Long.
A. R. Ellerker.	J. B. Moore.
T. R. L. Finnegan.	T. N. Reynolds.
R. V. H. Goulder.	B. Wotton.

Physiology.

G. F. Barnes.	C. D. Korn.
A. G. Bearn.	R. H. N. Long.
W. M. Dixon.	J. B. Moore.
M. E. P. Easton.	B. H. Prideaux.
A. R. Ellerker.	T. N. Reynolds.
T. R. L. Finnegan.	A. J. Swann.
R. V. H. Goulder.	

Pharmacology.

M. A. Barker.	I. Macdonald.
K. A. A. Campbell.	J. C. Matthews.
T. H. Eustace.	A. V. Morse.
J. Z. Garson.	H. W. Palmer.
T. J. Jones.	J. S. Smith.
H. A. Lane.	D. Q. Trounce.
D. O. Lloyd.	J. D. Whitehouse.

The Services

Awards

GEORGE MEDAL

Captain C. P. Blacker, M.C.

Change of Address

J. E. Spalding, M.S., F.R.C.S., 144, Crofton Road, Orpington, Kent. (*Tel.*: Farnborough, Kent 161.)

Births

LEE.—At Banff, on July 19th, to Margaret (née Pitt), wife of Ft.-Lieut. H. A. Lee, R.A.F., Malta—a daughter (Elizabeth Joan).

MURCH.—On July 17th, at New House Farm, Teynham, Kent, to Joan (née George), wife of Flying-Officer C. Patrick Murch, R.A.F.V.R.(D.), the gift of a son (Patrick Symon).

SPALDING.—On July 21st, to Katherine, wife of J. E. Spalding, M.S., F.R.C.S., at the County Hospital, Farnborough, Kent.—a daughter.

Marriage

BUXTON—THORNTON.—On July 27th, at the Brompton Oratory, John D. Buxton, M.R.C.S., L.R.C.P., to Kathleen "Bunty" Thornton, A.T.S.

PONDER-TIDMAN.—At the Royal Dockyard Church, Sheerness, on July 3rd, 1943, Surg.-Lieut. R. C. Ponder, R.N.V.R., third son of Dr. and Mrs. Constant Ponder, of Abbey Court, Maidstone, and Miss Beryl Tidman, Q.A.R.N.N.S.(R.), younger daughter of Mr. and Mrs. Robert Tidman, of The Cottage, Sandy Lane Road, Cheltenham.

PORTER—RICHARDSON.—On July 31st, 1943, at Orpington Baptist Chapel, Flying-Officer William A. Porter, to Phil M. Richardson.

SICHEL—LAWSON.—On July 24th, at Bournemouth, Gerald Robert Mackenzie Sichel to Betty Page Lawson.

EDS. { J.O.L. R.R.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE National Association for the Prevention of Tuberculosis held a conference in London recently, when many points of the familiar problems of the control of pulmonary tubercle were discussed. The Government schemes of allowances for patients undergoing treatment are coming into action slowly; they emphasise the essentially economic and social problems brought about by the disease—points frequently insufficiently appreciated by many students who will cheerfully talk of six months or a year's sanatorium treatment without realising what such a period means to a person with financial and family responsibilities. A number of students recently visited Preston Hall, where the economic aspect of tubercle receives special consideration; it is to be hoped that they benefited by their experience and that others will have an opportunity to do so in the future.

Non-pulmonary tuberculosis is also getting its share of attention. For many months pasteurisation of milk has been hotly debated in Parliament and both medical and lay press. The White Paper on milk policy is, at any rate, a step in the right direction. Briefly, the intention is to allocate areas where milk can only be sold retail if it is "heat-treated," T.T. or "accredited." Presumably the areas involved will be mainly populous urban districts and will not affect rural districts where the consumption of raw milk "straight from the cow" is greater and the danger of such infection is perhaps greater; but the bulk of the school population will get some protection, and the extension of the scheme to involve town and country alike, whilst impracticable at the present, may be envisaged as a post-war measure. A serious criticism which has been made is against the inclusion of accredited milk on the grounds that this grade of milk only offers very slight protection—criticism well backed by the frequent detection of tuberculous infection of such "accredited" milk supplies.

Another well-worn subject of war-time medical propaganda — diphtheria immunisation—has been brought to mind by a further supply of pamphlets from the Central Council of Health Education. In spite of the present partial measures, diphtheria is still one of the principal causes of death in young children. Problems due to occasional cases of diphtheria occurring in inoculated subjects are now being reported on. Under such circumstances diagnosis is more difficult, both on account of minor changes in the clinical disease and a natural reluctance to diagnose diphtheria in an inoculated subject; the possible occurrence of mild or subclinical throat signs and symptoms, followed by graver complications is a fact calling for great care and discrimination in fever work.

NURSING readers will, no doubt, have been greatly interested to read of the work of Russian nurses in accounts brought back by the British surgical mission to Russia. Their protean activities appear to range from nursing as we know it to building construction, camouflaging and parachuting. Women have always done many "male-type" jobs in Soviet Russia, but it is such activities that give an indication of the spirit of our Allies and the magnificent fight they are making.

Medical education in the Soviet appears to contrast sharply with ours in that about 90 per cent. of students are women, although the normal peace-time percentage of about 50 per cent. is also much higher than in this country. Discussions a few months ago indicated that an increase in the number of women doctors would be generally appreciated, but a conclusive ballot showed that at Guy's, at any rate, the admission of women students would not be well received—a view activated, we feel sure, by a realisation of the practical difficulties (and a modicum of pure conservatism), but not by any unpatriotic feelings.

General Principles of War Surgery

By W. H. OGILVIE, M.Ch., F.R.C.S., Hon. F.A.C.S.,
Brigadier, Consulting Surgeon East Africa Command.

(*Synopsis of opening lecture at a Refresher Course given in East Africa.*)

Although written some months ago, Mr. Ogilvie's article will, we feel sure, interest readers from two points of view ; in the discussion of the important differences between war surgery and peace-time surgery, and in the mention of the surgical difficulties in the rather distant East African campaign—a campaign which was undoubtedly unique in both its military and medical problems.—ED.)

ONE of the basic difficulties of the medical services in war is that each officer is apt to find himself in charge of some type of work with which he is wholly unfamiliar, without books, without medical contacts, and without that most important of all sources of self-education, the study of his own results. This difficulty applies, perhaps, more to the surgery than to other branches of war medicine, but it is inherent in all. In war no individual has the opportunity for self-education, for profiting by experience—that is the only sure method of advance in peace-time surgery.

The surgeon at a field ambulance (and I am referring for the moment to the role of a field ambulance in more traditional warfare, and not to their work in Abyssinia) has few opportunities of learning how his cases travel down ; how effective are the measures he takes to relieve shock, stop hæmorrhage, ease pain ; whether his indications for operating at such an advanced post are right, or whether the list should be extended or curtailed in view of the particular circumstances of the army of which he forms a part ; whether his apparatus for immobilising fractures and his modes of transport are the best for the length and quality of the journey on which his wounded must be sent.

The C.C.S. surgeon does not realise to the full the difficulties of those in front and may feel without reason that patients could have been more carefully dressed, better immobilised, or sent down quicker. He may have practical suggestions on these points, but has few opportunities to discuss them with his colleagues further forward. In his own work he develops along certain lines, but he does not know how others on other parts of the front are tackling the same difficulties, whether they can help him or he them. Above all, he does not know how his own methods work out, not merely immediately, but in the long run. The suture of wounds may be mentioned as an example of this difficulty. In the spring of 1940 many young surgeons, both in the British and French Armies, adopted the practice of primary closure of wounds of moderate severity after excision. The results were often disastrous. The majority of sutured wounds became grossly infected, and many arrived at the base with gas gangrene needing immediate amputation, while some patients lost their lives because an apparently trivial wound had been sutured. The matter was taken up with considerable vigour by the consultants of both armies, but by the time of the French collapse the folly of primary suture under the conditions then prevailing had not yet been sufficiently appreciated. At the time I left England a young British surgeon was recounting his successes with primary suture, though the failure of those same cases was well known to many of his brother officers, but not, as yet, to him. When I landed in East Africa, my first (and about my last) shock was the discovery that sutured wounds were coming down from Somaliland in the most ghastly mess.

Base hospital surgeons see the *final* result and, when it is good, are apt to take the credit themselves. If they attribute the success to the man further forward, they cannot or do not congratulate him, or have a chance to discuss the difficulties of any method or to suggest improvements. If they find the result bad they tend to blame it entirely on " that damned fool at the C.C.S." without allowing for the hazards of transport or the mishandling of other " damned fools " *en route*.

These difficulties may be mitigated in three ways, none of which have been particularly effective in East Africa.

The first is by the work of the consultant. The problems of a peace-time consultant —that is, the discussion of difficult cases or of questions of technique in operative surgery—are not really his job ; it is to the commanding officers and heads of surgical

divisions that these tasks usually fall. The real job of a consultant in war is to act as an observer and a shuttle, bearing surgical experience between the front and the back areas and collaterally. He is the only medical officer in the Army who can get at all the books and the journals, who is in touch with civil and military medicine, who can follow the wounded man from battle to base and from tropical plain to upland, and who has the opportunity to go round with criticism, advice and praise, with good tidings and bad, to find out wants and, as far as possible, to supply them. These, I need hardly say, are the functions of the infallible consultant attached to a perfect army conducting a text-book campaign in Utopia. My first month went well. After a hurried look round the base hospitals, I managed to fly up to Mogadiscio, catch the 11th Division at Giggiga and attach myself to one unit or another, till we entered Addis Ababa. Since then the difficulties of distance and transport have kept me from any but very occasional visits to a very few units, and, except for those within two hundred miles of Nairobi, I have met more of my surgeons in the Muthaiga Club than in the field.

The second device to spread information is by the system of return postcards, allowing the forward surgeons to learn the final result of their work. In a compact war such as that of the first year in France, or that in Libya, the system works fairly well; in East Africa postal communications have been so dilatory and erratic that the telegraph has been the only medium whereby information can arrive before its context is forgotten.

The third method is by means of medical societies and revision courses—the best, but the most difficult in practice, since discussions and lectures are necessarily least accessible to those that need them most. In times of preparation, under conditions such as those obtaining in the commands in England, or in periods of stationary warfare, such as existed in the British Expeditionary Force in France during the first six months of the war, such facilities are easy to arrange and work fairly satisfactorily. These also, unfortunately, are times and places where there is not very much to discuss except theory, and where other means of information such as libraries and periodicals are readily accessible. When fighting starts distances mount, communications are strained, men cannot be spared for purely educational purposes, and the project is impracticable. These have been our circumstances all along in East Africa. A medical society has been going in Nairobi for the best part of a year. But though a revision course has been planned on several occasions, it has never been possible to hold one till now.

To return to my subject, "the general principles of war surgery." Is it possible to discuss the principles of war surgery apart from the principles of surgery? I think that it is not only possible, but necessary. War surgery is different from peace surgery:—

(i) Its underlying aim is different.
(ii) The surgeons performing it are different.
(iii) The patients are different.
(iv) The conditions for which they are treated are different.
(v) The external circumstances are different.
(vi) The methods are different.

I will take these points, in turn, very briefly:—

(i) *The Aim of War Surgery.*—While the aim of peace-time surgery is to do the best possible for the individual, the aim of war surgery is to do the best possible for the Army, and indirectly for the country it represents. Thus it has two main objects—to save life and to enable a soldier to perform his military duties more efficiently.

In battle casualties the duty of the military surgeon is to save life and, still more, to save useful life. When time permits he must do his best for every wounded man; when the casualties are thronging on him he may have to give priority to a group of limb wounds in which he can avert infection by timely operation over a head or abdomen whose operation may take him an hour and a half, with no more than a 30 per cent. chance of survival, and very little of a useful or happy life if he does survive. It may seem brutal, but in the end it is kind; for the best way to save wounded men is to stop the war. The best way to stop the war is by winning it, and the best way to win it is by keeping the maximum number of fighting men in circulation.

Another aspect of wound surgery is that each surgeon is part of a war machine. He stands at one point on the production band, doing his own bit to the damaged human chassis and handing it on to the next worker, till it finally emerges at the other

end, reconstructed and as good as new. No patient is his individual property. He does what is essential at his stage, endeavouring always to make the next man's job as easy as possible. It is essential, therefore, that he should know what the experts further back require of him. The cranial surgeon, that he should limit himself to a careful toilet of the scalp and skull whose object is to avert infection and allow primary closure and primary union, but that he should not explore the brain or attempt to remove any but surface foreign bodies from it. The facio maxillary surgeon, that he should excise nothing that can possibly be left, bring back skin and mucous membrane, as far as possible, to their original site with fine interrupted sutures, but make no attempt to slide flaps or do primary closure of gaps, but that with wide loss of jaws he should cover the bone, if possible, by muco-cutaneous suture, and that he should get the patient to a plastic centre with all the speed possible. The orthopædic surgeon that he should avoid wide removal of bone.

Civilian surgery in the Army is judged by one criterion only : " Will the proposed operation make the man fit to perform his military duties more efficiently ? " Acute emergencies, strangulated hernia, appendicitis, perforated ulcer, acute cholecystitis, must, of course, be dealt with immediately. But pre-existing disabilities should not be treated unless they have been aggravated by military service to an extent that unfits the soldier for his work and can be corrected with reasonable certainty of his return to work in the same or a higher category within a period of two months. In many cases, before operation is undertaken, it should be carefully considered whether the man should not be placed in a lower category or returned to civil life, postponing the correction of his disability to the end of the War.

Further, any surgery other than that of accidents or acute emergencies must be done under the best conditions possible. The civilian who picks his own surgeon is getting what he asks for : the soldier must get the best deal the Army can give him. The place for major cold surgery is the general hospital, and certain branches of work, notably plastic, cranial, thoracic and major orthopædic surgery, should be sent to special centres.

Then, again, war surgery is only a part of war and the surgical aspect can never be the dominant one. The aim of the command in any civilised army is to give the wounded the best possible treatment compatible with winning the war, but if anything is allowed to interfere with military efficiency, the lives of well and wounded are risked together. Guns and supply dumps must have first choice of sites : ambulance transport going back must not interfere with troops, communication and food going forward.

In modern war the difficulties are greatly increased by the absence of any fixed plan, and the liability of any tentative plans to be changed within a matter of moments. In the last war the general preparing an offensive would tell his director of medical services his intended line of advance and would indicate where he expected to receive casualties and how many, and the lines along which they could be evacuated. To-day any such detailed planning would rob the attack of the essential element of surprise ; further, at any time a chance opening may lead to a break through and an advance in a direction and at a speed that may not have been expected.

(ii) *The surgeons differ* as well as the surgery. Surgeons are no more alike than solicitors or stockbrokers, and in war the talents of each are best suited to some niche in the military-surgical machine, not always the one he pictures himself as filling. The first-class peace-time surgeon may be a nuisance in the war zone. On the other hand, the kind of men who make good surgeons in the forward zone of any army are not necessarily as good in peace-time, and in war have a tendency without adequate supervision to develop into undesirable types, the " death or glory boy," who would rather operate on one potential corpse than six good soldiers, and the publicity merchant, who is out to beat the record for mortality, for feet of intestine resected and so on.

Manual dexterity, speed, decision and stamina are all essential to surgeons working in the forward units. These qualities point to young men as best for such posts. Judgment, however, is even more necessary and this is not an invariable accompaniment of youth. The front line surgeon must be able not only to operate on a wound quickly and safely, but to deal with a group of men whose wounds are part of their morbidity and whose right handling is a part of the problem of his army and of the country it defends. In such a group he must decide which are best left alone and which need operation ; he must classify the latter into those demanding priority in the theatre, those who will not stand any handling till they have been resuscitated, and those who can await their

turn without serious risk; when operating he must know in what order to tackle multiple wounds, which to treat radically and which with caution, when to be bold and when to stop. A division of labour is therefore indicated in front line surgery between the executive or technical and the advisory functions and, among the advisory posts, none is more important in heavy fighting than the sorting officer at a C.C.S.

(iii) *The Patients in War are different.*—The majority are soldiers, and most soldiers are picked human material, but in total warfare casualties are encountered in infants and the aged, and in those already enfeebled by malnutrition and chronic disease. Yet even among soldiers the resistance to trauma and infection varies greatly, depending among other things on :—

(*a*) Circumstances affecting him within the period immediately preceding the injury, such as exhaustion, lack of sleep, hunger, thirst, exposure to cold or heat, and emotional stress. In the last war the wounded soldier had usually spent days in mud-soaked trenches with little sleep and indifferent food, and was battered in mind and body by prolonged bombardment. Conditions even worse must prevail on the Russian front, but in East Africa we have rarely had to deal with men exposed to hardship.

(*b*) Coincident illnesses, particularly epidemics and tropical diseases. In the last battle of the Piave in 1918, many men died from relatively slight wounds because they fell victims at the same time to the influenza epidemic. In Africa malaria may always be expected as a complication. Though the native soldier is magnificently built he rarely has a hæmoglobin percentage above 80, or a normal differential white cell count. Many are the victims of four debilitating conditions —malaria, worm infestations, gonorrhœa and syphilis.

(iv) *The Conditions with which War Surgery deals are different.* War surgery is traumatic surgery, but with the factors of laceration and contamination usually more marked than in civil accidents. Yet it cannot be reduced to rules, for though its main problems remain the same, the details differ from one war to the next, and from one front to another in the same war.

The degree of laceration varies, depending chiefly on the type of weapon preponderating at any time or on any front, but to some extent also on the nearness of the medical services to the fighting. The surgery of the last war, at any rate in its later stages, was largely that of wounds inflicted by fragments of high explosive shell casing of moderate size. In this war we have, on the one hand, many wounds due to rifle or machine-gun bullets or to projectiles travelling with even less velocity and causing less laceration; on the other hand, we have the injuries caused by aerial bombardment in the neighbourhood of the hospitals themselves, wounds and crushes of such severity that in field warfare they would never survive transport to the field ambulance. In East Africa air attack has been negligible and the wounds we have seen have been almost entirely those caused by machine-guns, and by anti-personnel grenades that were left behind as booby traps rather than thrown. Machine-gun spray, when it hits a man at body level, is usually fatal, so very few head, chest or abdominal wounds have survived to reach even the field ambulance, and very few, indeed, to reach the base. Our experience has been, above all, of limb wounds. The grenades have caused dreadful smashes of hands and feet, often leading to amputation, and, in a few tragic cases, to loss of both hands and both eyes.

The degree of infection varies, depending on the terrain in which the fighting takes place, the immediate surroundings of the fighting man himself (*e.g.*, whether he is in a trench or a tank) and the soiling or otherwise of his clothing. In the last war the well-manured mud of Flanders was carried into the body by every projectile and every bit of clothing. Heavy infection was the rule and gas gangrene very common. In the East African campaign our men have been fighting in arid bush, on denuded plateaux, or over sparsely cultivated land, but never in well-manured agricultural country, and seldom in really wet surroundings. Contamination with pathogenic bacteria is far less obvious even in lacerated wounds, and anærobic infections have been rare.

(v) *The External Circumstances of War Surgery are different.* As our transatlantic allies would say "and how!" Many of my teachers would turn in their graves if they saw the conditions under which I myself have operated in this war; many of the young men in England who write about doing wound dressings with all the pomp and circumstance of a major operation, and of spraying the floors with oil to lay the dust might get a shock. It might even do them good.

Military realism must temper surgical idealism, so that those making surgical arrangements must look at them from two points of view, what is desirable and what is practicable. Buildings and equipment must strike the mean between efficiency and mobility, and the fiercer the war the more mobility becomes the key to everything, for only units that can move as fast as the troops can keep within the zone of primary surgery and do something, however crude. A surgeon at hand is worth two in the bush; one sitting in a chromium-plated theatre three days away is just a pain in the neck, though he may have as many degrees as a thermometer.

The primary surgery of wounds must therefore be kept down to bedrock simplicity, but even so certain things are indispensable :—

shelter of sorts;
a table of sorts;
a light of sorts;
a surgeon, anæsthetist and assistant;
a minimum supply of instruments, that must allow the primary surgery of cranial and abdominal wounds;
an adequate stock of sterile dressings and materials;
plaster, vaseline and sulphonamides;
the apparatus and materials of resuscitation;
the means to keep and look after the more seriously wounded under cover.

In this campaign the surgical work has fallen entirely to the field ambulances, units not intended to do more than urgent surgery, usually to single companies and even smaller detachments. Their equipment was, in most cases, inadequate and, without captured materials, they could not have done the work they did.

(vi) *The Methods are different.* Wounded men die from three causes—hæmorrhage, shock and infection. Those killed immediately or dying within the first two hours usually die from hæmorrhage; those who die in the first two days do so from shock; and those surviving two days and dying in the next two weeks usually succumb to infection. Hæmorrhage and shock need prior treatment over anything else, and the methods of combating them demand a discussion to themselves; nevertheless, it is the prevention of infection that is the main task of front line military surgery and the chief job of the war surgeon.

A war wound consists of a track through the tissues, which are damaged to an extent and to a depth that varies with the nature of the weapon or projectile causing the wound. In the track lie blood clot and dirt, and possibly the missile or bits of clothing or other foreign matter carried in by it. Bacteria will be introduced with the missile and foreign material; the majority are harmless, the pyogenic cocci which are often found in wounds involving the upper air passages, and the anærobes of tetanus and gas gangrene which may be introduced by manured soil or fæcal contamination, being the chief exceptions. These bacteria are first lying free in the wound track on the foreign matter with which they were introduced; later they multiply on the devitalised tissues and body fluids they find about them, and invade healthy structures. In the first stage the wound is said to be contaminated, in the second infected, and the interval between contamination and infection is variable, but may for practical purposes be accepted as not less than six hours. The most certain means to prevent infection in war wounds is therefore by the prophylactic excision of the whole wound track within the grace period of six hours, an operation summarised in the term *débridement.*

This much was learned in the last war. In this one three new methods have appeared—chemotherapy, the use of preserved body fluids, and the closed plaster treatment of wounds—which have so profoundly modified the outlook in favour of the wounded man, that we must reconsider our outlook.

The disadvantages of débridement are that it takes time and that it often leads to profound disability. Wide excision of tracks through muscle masses such as the thigh often leaves crippling weakness, removal of bone fragments may be followed by non-union or excessive shortening, and near a joint by a flail or partly ankylosed joint. If it is necessary to save life these disadvantages must be faced. Our experience of the closed plaster method on this front is that when drainage of the whole track is free and immobilisation complete, the results are so uniformly good that wide excision is unnecessary. Foreign matter and dirt and obviously dead tissues should be removed, but a slow and meticulous débridement in the 1918 sense is not required, and bone fragments should not be removed unless they are separated from all their attachments. This advice applies to the war surgery of the East African campaign.

With regard to drainage I would only say that skin must not be removed unnecessarily but may be incised in the lines of the deeper planes ; that the superficial parts of a track should be enlarged in the lines of muscle groups to allow all its recesses free access to the surface ; and that drainage should be by gauze impregnated with some oily medium rather than by dry or antiseptic packing. Vaseline has proved its worth in many fields and in thousands of cases ; in the difficult conditions we have encountered on this front, where fresh sterilised dressings may be unobtainable in the forward operating units, self-sterilising media such as Z.I.P.P. and 25 per cent. sulphanilamide vaseline are finding increasing support.

One final point I would urge on you—the need for improvisation in forward surgery. We are working here in one of the most outlying of the many theatres of war in which our armies are engaged, and our equipment is lacking in many essential particulars and is likely to be still further depleted. Things like surgical instruments, catgut, cellona, bandages and rubber gloves will be hard to replace when they are used up or wear out. Nor should we ask for anything that we can supply ourselves, for we can do no greater service to the war effort than by sparing shipping and every form of transport. To th qualities needed by a good front line surgeon I would add one other—the Heath Robinson outlook.

In our forward operating units, isolated field ambulance companies, three essentials were nearly always lacking—theatre lighting, plaster apparatus, and continuous drip infusion sets ; the extent to which they improvised these were an index of the ingenuity and fitness for war work of their surgeons.

Lastly, I would beg all front line surgeons to take to linen thread in place of catgut for all their ligatures. Enough for twenty major operations can be carried in a small spool in the hand. Further, a reel costing 1*s.* 10*d.* is equivalent to 300 tubes of catgut costing £7 10*s.* and taking up a cubic foot of storage space. Apart from considerations of cost and space, thread ligatures are far better in war surgery ; their sterility is absolute, unlike catgut which is a foreign protein they produce no tissue reaction and, once tied, they remain secure and are not displaced by subsequent manipulations.

When, How and When Not to Use Sulphonamides

By N. M. JACOBY, M.D.

FOREWORD.

THIS article does not pretend to be comprehensive. It is dogmatic and lays itself open to criticism. Much has been purposely omitted, for it was felt that a long discussion involving all the pros and cons would overcloud the objective of producing a simple and, if desired, easily remembered scheme for using a popular, potent and much-abused group of drugs.

Much has already been written on the sulphonamide group of drugs and more is doubtless forthcoming. References to "M. & B." are as common in the lay press as in the medical journals. Every patient expects it and every doctor prescribes it. Unfortunately, not every patient requires it and not every doctor knows how to use it. Obviously, with so new a drug, there are bound to be differences of opinion as to the indications for and methods of using it. The scheme here outlined is based on principles that have been tried in practice and found not unsatisfactory.

THE WHEN.

The action of the sulphonamides is against bacteria, *not* diseases. For instance, it is wrong to say the drugs are effective in pneumonia. They may be effective in pneumococcal pneumonia, but they are useless in tuberculous pneumonia. Bearing this in mind one can say that *the indication for sulphonamides is when there is an infection with an organism susceptible to their action.* (There is one important proviso. In the presence of collections of undrained pus the drugs either don't work or their efficacy is enormously reduced.)

These bacteria can now be enumerated :—

1. Hæmolytic streptococci.
2. Pneumococci.
3. Meningococci.
4. B. Coli Communis.
5. Gonococci.
6. Dysenteric group.
7. Staphylococci.
8. Strep. Viridans.
9. B. Influenzæ.

Note.—Nos. 7, 8 and 9 are less susceptible than the others.

THE HOW.

A. Which Sulphonamide to Use.

The choice of drug is simple. Pick one effective against the organism causing the disease. Broadly speaking, there are seven types of sulphonamide and they can be used against the organisms, as shown in the following table :—

Type of Drug.	*Bacteria against which it is Effective.*
Sulphanilamide	Streps. Meningococci and B.C.C.
Sulphapyridine	Streps., Pneumococci, Meningococci, B.C.C. and B. Influenzæ.
Sulphadiazine	As for Sulphapyridine.
Sulphamethazine	As for Sulphapyridine.
Sulphathiazole	Staphylococci in addition to those given against Sulphapyridine.
Sulphaguanidine	Dysentery Group.
Sulphsuccinamide	Dysentery Group.

It may be noted that no mention is made of sulphacetamide in column 1 or gonococci in column 2. The reason for this is that sulphacetemide is used exclusively in ophthalmology, and the treatment of gonorrhœa is a specialised job. In neither of these branches has the author any experience.

B. Dosage.

The object is to get an optimum blood concentration rapidly and maintain it as long as necessary.

(i) *Decide the Total Dose for the First Twenty-four Hours.*—A good full dose for the first twenty-four hours is about 3 grammes for children up to one year, 4 grammes from 1–3 years, 5 grammes from 4–6 years, 6 grammes, 7–10 years. The dose then rises slowly to about 9 grammes for an adult. These doses may be reduced for mild cases, but they can also be exceeded if need be.

(ii) *Frequency of Administration.*—As a rule give the drug four-hourly, starting with a larger dose—*e.g.*, if it has been decided to give 7 grammes in the first twenty-four hours, prescribe 2 grammes statim and 1 gramme four-hourly.

(iii) *Route of Administration.*—Give the drug by mouth. If the patient vomits it try another suitable preparation. If this fails, too, and only then, consider giving it parenterally.

(iv) *What to Do after the First Twenty-four Hours.*

(*a*) *If the patient shows no improvement.*—Give the same dose for the second twenty-four hours. If there is no improvement after this give the same dose for the third twenty-four hours. If there is no improvement after this you may be treating an unsuitable case. Reconsider the whole position and, if you are still sure the case is suitable, continue giving a dose of the same amount, or one the patient will tolerate, until toxicity or improvement indicate a reduction in dosage or complete withdrawal of the drug.

As soon as the patient shows improvement proceed as in (*b*).

(*Note.*—Improvement is judged by the clinical condition of the patient, combined with a fall in both the temperature and pulse rate.)

(*b*) *If the Patient shows Improvement.*—Give the same dose for the second twenty-four hours. If improvement is maintained give about two-thirds of the dose in the third twenty-four hours, half the dose in the fourth twenty-hours and one quarter the dose in the fifth twenty-four hours and then, if all is well, withdraw the drug.

It will be seen that no special set course of treatment is advised in any given disease. It is much more satisfactory to judge each case on its merits every twenty-four hours. Although some people would disagree, always give a minimum course of five days, because, if the drug is withdrawn as soon as the temperature falls, it often rises again in a day or so, and the whole process has to be repeated, thus increasing the time spent in curing the disease.

THE WHEN NOT.

Do not use sulphonamides in the following circumstances :—

1. In unsuitable cases—*i.e.*, infections with an organism not susceptible to the drugs.

2. In cases that will get well just as quickly and certainly without them—*e.g.*, sore throat or upper respiratory infection.

3. In cases of P.U.O.

4. In the presence of collections of undrained pus.

5. When the blood cell count is low. (This is not an absolute contra-indication.)

6. When the toxic effects and constitutional disturbance outweigh the good the treatment may do—*e.g.*, the advent of hæmaturia or anuria.

Enlargement of the Spleen

By EL HAKIM KEBIR PASHA.

WITH so many thousands of people from this country touring the Middle and Far East, it will not be surprising if enlarged spleens become more fashionable than ever. Perhaps, therefore, it may be worth saying (in as few words as possible, Mr. Editor) something about it.

There are the acute enlargements—usually met with in the course of acute infective fevers—which may be considered first of all. These spleens are never very big, and most of us will remember dipping our hands under the left costal margin and not being very sure whether what we feel is really the spleen or whether it is rectus muscle. When it is really big enough to feel we may be lucky and have no doubt about it. We are always especially painstaking if we suspect fevers of the enteric group, but even if such a diagnosis be confirmed, it is surprising how often we are not quite certain whether we could feel the spleen or not. All of which goes to show that the degree of enlargement in the acute varieties may not be very great. You are more likely to find an easily palpable spleen in malaria, I think, than in most of the others. When I say that, I have in mind the sort of enlargement one gets in the acute stage of a first or second attack, and not the chronically enlarged organ of an old malaria patient. Undulant and relapsing fevers and typhus also have easily palpable spleens. So may have septicæmia and, to a lesser degree, erysipelas. It may also be felt—not always easily—in small-pox, scarlet fever, diphtheria, pneumonia and influenza, and even in acute rheumatism and influenza. It is often found in general (acute) tuberculosis. Malignant endocarditis may cause considerable enlargement and tenderness as a result of splenic embolism. Injury, with splenic hæmatoma, will do the same. Torsion of the pedicle causing strangulation gives rise to very acute signs, as would be expected.

Moderate enlargement may be found in the acute Plummer-Vinson syndrome, but, in my own experience, this is not invariably the case. When I have found it I have always looked for another possible cause.

In all the above conditions, with the possible exception of malaria, the enlargement —or, rather, the palpability—of the spleen disappears with the subsidence of the acute condition with which it is associated. In malaria the palpability is more likely to persist, especially after recurrent attacks.

In the chronic enlargements there are, roughly speaking, two classes of conditions with which they are associated. The first of these includes a group of diseases in the names of which that of the spleen is incorporated because of the changes which the organ undergoes, resulting eventually in enlargement to a degree that may be correctly described as "enormous." For example: splenomegalic polycythæmia (Osler's disease), splenomegalic cirrhosis, Egyptian splenomegaly and splenomedullary leukæmia. In this class also occur lymphatic leukæmia, mixed leukæmia, pseudo-leukæmia infantum, chronic malaria (ague-cake), kala-azar (Leishmaniasis), Gaucher's disease (splenic anæmia of young persons), Still's disease and familial acholuric jaundice.

The other class of chronic enlargements includes those mainly associated with general constitutional diseases such as Hodgkin's disease, pernicious anæmia, rickets, hepatic cirrhosis, congenital syphilis and thrombosis of or mechanical pressure on the portal vein (glands, tumours).

In this class the enlargement is usually greater than that associated with acute infections, but is only of moderate degree and never approaches the great size met with in the former class.

There are other causes of enlargement not often seen in this country—*e.g.*, trypanosomiasis gambiense, Chaga's disease (South American trypanosomiasis), Bartonellosis and plague.

Together with the liver the spleen may enlarge as a result of backward pressure in chronic valvular disease of the heart or obstruction of the inferior vena cava.

In a long experience I have never seen a case of *primary* cancer of the spleen. It must be exceedingly rare.

I advise all students to practise palpation of the spleen. If it is not enlarged you are very unlikely to feel it.

Reviews

War Wounds and Injuries. Second Edition. Edited by R. MAINGOT, E. G. SLESINGER and ERNEST FLETCHER. Published by Edward Arnold & Co., London. Pp. 489. *Price* 35*s. net.*

THE first edition of this book consisted of a series of articles on war surgery which had been published in the *Post-Graduate Medical Journal.* The second edition has been completely revised under a new editorial board. Many new articles are included, and a most imposing list of contributors has been assembled to produce an authoratative and up-to-date account of war wounds and injuries.

The book contains twenty-two chapters dealing with all aspects of war surgery. The general standard of the articles is extremely high, but for clarity of expression the outstanding contributions are those on flesh wounds, nerve injuries, the skull and brain, the spine and spinal cord, the chest, facial injuries and sulphonamide therapy. In the latter chapter is included an excellent table setting out the uses and undesirable reactions of the various sulphonamide compounds.

No labour has been spared in revision of the articles and each is written by an expert in his particular field. The whole book is well balanced and its production is excellent. It can confidently be recommended to all interested in war surgery; it is of small and convenient size and undoubtedly represents the best and most concise account of the subject so far published.

S. H. W.

Modern Operative Surgery (Carson's). Third Edition. Volume I. Edited by G. GREY TURNER. Published by Cassell & Co., Ltd., London. *Price* 50*s. net.*

THE production of a work of this type in war-time is a credit alike to the editor, contributors and publishers; particularly is this credit due when the various results of enemy action are fully realised. The standard of production, although conforming with the authorised economy standard, is excellent, and the plates, many of which are new, are magnificent.

It is nearly ten years since the previous edition of this well-known book. In this time there have been many developments in operative surgery and a combination of rewriting and thorough revision have brought the book up to date. Nevertheless, the editor is careful to point out that it has been regarded as most important to present

those methods that have stood the test of time, and that a considerable period must elapse before it can be said that a given modification, however striking or spectacular, is a real improvement rather than a mere change in technique.

The list of contributors remains much the same as in the previous edition, but four new names appear to replace deceased authors. Professor Grey Turner, in addition to writing an enlarged editor's introduction on general surgical principles, has made himself responsible for nine of the twenty-two chapters in the present volume. The subjects dealt with include anæsthetics, surgical tuberculosis, general orthopædics, operations on joints, tendons and bones, amputations, thoracic surgery, the spinal cord, peripheral nerves, blood vessels, malignant disease, the breast, abdominal injuries and all other aspects of abdominal surgery.

There is little to criticise in the subject matter and there are no noticeable omissions. Each chapter provides a full account of the operations performed in a particular region, together with their indications and possible complications. The book will certainly remain one of the best standard works on the subject and the appearance of the second volume in the near future is eagerly anticipated. S. H. W.

Materia Medica for Nurses. By W. GORDON SEARS. Published by Edward Arnold & Co. *Price 5s.*

IN this book Dr. Sears has added another very useful book to those he has already written for nurses. It is interesting and full of practical applications. The first chapters deal with terminology, legal control of drugs, pharmaceutical preparations, methods of administration and action of drugs. The classification of the drugs is according to the systems on which they act. In practically all cases the group is preceded by a brief account of the physiology of the system or organ, which is, of course, the only approach to the subject. Many nurses would appreciate more details in this respect. They want to know, as Dr. Sears states in his introduction, exactly how it operates. The practical nature of the book enhances its value to nurses, but for the general management of sleeplessness nurses could refer to text-books on nursing. Small sections in other parts of the book could be relegated to a text-book on medicine, so making room for more pharmacology. At the end of the book useful information on weights and measures, solutions, the prescription and a table of doses is to be found. The print and paper are very good. The book can be thoroughly recommended and should serve as a useful companion to medicine for nurses by the same author.

F. T.

THE JUNIOR'S LAMENT.

The Junior Pro.
Can never know
Why she has to struggle so
To clean and clean and clean again,
From interesting tasks refrain
And use her feet more than her brain.
When she's a senior she can see
That these things simply have to be,
So tells her juniors so with glee.
And so all up the scale we find
That each forgets what lies behind
And thinks her juniors deaf and blind.
When Sisters were just Junior Pro's
They used quite often to suppose
A Sister's life a thornless rose,
But when they try it they find out
That doctors can just turn and shout
And order even them about;
In view of which it seems to me
That I should really try to be
M.R.C.S., L.R.C.P.,
Instead of S. R. N.

"JO."

Sport

Cricket

Guy's drew with Middlesex Hospital on Saturday, July 31st, at Chislehurst.

Middlesex batted first and scored 202 for 9 (declared). This was due chiefly to a fourth wicket stand of over a hundred. The Guy's bowling was very mediocre and the fielding poor, but allowance must be made for the heat.

When Guy's batted very little initiative was shown. At close of play the score was 143 for 7, which was poor considering the perfect wicket.

Team.—E. W. R. Alderman, G. W. Garland, D. C. Boyd, G. Thompson, L. D. Carton-Kelly, A. Brown, R. Finney, P. L. Brangwin, G. R. Wotton, K. Pritchard, I. A. H. Munro.

On Sunday, August 1st, Guy's drew with Malden Wanderers at Malden.

Malden won the toss and put us in, but rain started just before play began and no play was possible before tea.

After tea Guy's scored 120, including a very bright 33 by L. D. Carton-Kelly. Malden were always struggling for the runs against aggressive bowling by Alderman and they soon got behind the clock. At close of play they were 108 for 8 wickets.

Team.—E. W. R. Alderman, G. W. Garland, D. C. Boyd, L. D. Carton-Kelly, R. G. L. Brittain, R. Finney, P. L. Brangwin, J. R. Trounce, D. Q. Trounce, A. G. Ellerker A. N. Other.

Hospital Information, etc.

Notice

We have been asked by the Medical School to publish the following note from the Examining Board :—

Candidates *who may wish to take both M.B. and Conjoint Final Examinations*, when sending in their entries for any part of the Final L.R.C.P., M.R.C.S. Examination (closing date September 14), should state on their applications *what subjects* of the M.B., B.S. they are taking, and every effort will be made to avoid any clash in the arrangements of the two examinations.

Pass List

UNIVERSITY OF LONDON.

M.D. Examination (Pathology).

July, 1943.

R. E. Rewell.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

July, 1943.

L. P. R. Fourman.

Papers by Guy's Men

Guy's Hospital Reports.

1942, Vol. 91, Parts 3 and 4.

Contents.

Brock, R. C. Observations on the anatomy of the bronchial tree, with special reference to the Surgery of lung abscess. P. 111.

—— The level of the Interlobular fissures of the lungs. P. 140.

—— Hodgkiss, F. and Jones, H. O. Bronchial embolism and posture in relation to lung abscess. P. 131.

Ryle, John A. Rectal Pain. P. 147.

Eckhoff, Nils L. Leiomyoma of the Stomach with report of a case. P. 153.

Kilpatrick, F. R. A note on Syme's amputation with report of a case of forty years' duration. P. 157.

Rewell, R. E. A case of squamous-celled Carcinoma of the Ovary. P. 163.

Parfitt, J. B. Presidential Address. *Brit. Dent. J.*, 1943, **75**, 29.

Hurst, Sir Arthur. Nervous disorders of swallowing. *J. Laryngol. Otol.*, 1943, **58**, 60.

Eckhoff, Nils L. Infection of the Hand. *Clin. J.*, 1943, **72**, 130.

Behrmann, Simon. "The Frenzy," *Ibid.*, 142.

Birks, P. H. Symptomatology of Malaria. *Brit. Med. J.*, 1943, i, 784.

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Payne, W. W. Vitamin C in School Children. *Lancet*, 1943, ii, 819.

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Symonds, C. P. Medical Annual, 1943 : Sciatica, p. 310.

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Pusey, R. F., and Another. A case of Cleido-Cranial Dysostosis showing Failure of Eruption of Teeth. *Ibid.*, 11.

Browning, S. H. Tuberculosis of Conjunctiva. *Proc. Roy. Soc. Med.*, 1943, **36**, 407.

Change of Address

F. M. Brown, Major, R.A.M.C., AMGOT, 15th Army Camp, B.N.A.F.

R. W. B. Ellis, Wing-Cmdr. R.A.F., A 9909, B.N.A. Air Force.

J. W. Lee, Lieut. (J.G.) D.C.U.S.N.R., No. 319 U.S.N., c/o U.S.F.P.O., London, W.1.

A. C. Hancock, M.C., M.B., B.S., Clay Point Flushing, Falmouth.

R. S. Vine, Major, R.A.M.C., H.Q. British Military Administration, Tripolitania.

D. G. Vulliamy, Lieut., R.A.M.C., 257675 R.C.G. AZ Draft, APO 4815.

Mentioned in Dispatches

Lieut.-Col. A. Simpson- Smith, R.A.M.C.

Major (Temp. Lieut.-Col.) T. McK. Robb, R.A.M.C.

Captain (Temp. Major) J. H. Mayer, R.A.M.C.

Casualty

Captain J. L. G. Hartley, R.A.M.C.

Births

DIMOCK.—On August 1st, 1943, at Benges Nursing Home, Hertford, to Betty (née Leigh), wife of J. R. Dimock—a son.

JOHNSON.—On August 11th, 1943, at York, to Kathleen (née Haddakin), wife of Brian D. Johnson, M.R.C.S., L.R.C.P.—a daughter —Sally Clare.

Deaths

MULLINS.—On August 2nd, 1943, suddenly, at Clater Park, Bringsty, near Worcester, Henry R. Mullins, O.B.E., M.R.C.S., L.R.C.P. (aged sixty).

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THIS week has seen the end of August and with it the end of the first holiday season for four years. During the last four weeks organised teaching has fallen very low, but Out-patients have been undiminished. Unfortunately, they take their holiday in September, and even now London Bridge Station shews a scene reminiscent surely at a distance, of the flight before an invader. So now from a state of patients but no doctors we have doctors but no patients—with the rider that hops ripen at most inconvenient times. However that may be, winter is our next worry with all its attendant ill-health.

A doctor's family is notoriously less well cared for medically than even the least deserving of his patients—probably with little justification—while the doctor himself pays scant attention to his own health. The reason for the latter is not far to find—it is manifestly more difficult to recognise illness in oneself than in others—especially when that illness has been only gradually developing, where there is little change from week to week and where one is too short-sighted to mark the trend over months. Secondly, there is a tendency for the profession, knowing full well the possible implications of signs and symptoms, to shun any investigations likely to confirm their suspicions. Thirdly, and most important, the medical profession under its present organisation can least of any occupation afford the time to recuperate from some chronic illness; this last not solely for financial reasons, but because arrangements cannot be made for the proper care of their patients—circumstances which pave the way for heroic sacrifices, but which are not for the ultimate benefit of the community. These difficulties, we are promised, will be solved after hostilities have ceased, but certain more immediate problems must be met before this time.

The health of students depends on a number of factors, certain of which operate in peace-time, others having only arisen from war conditions. All are now subjected to a more concentrated course of study with the loss of time for exercise and recreation this entails. While no one would wish to criticise the adequacy of the present diet, it is clear that it does not reach that standard which is essential for the maintenance of perfect health. So we have conditions leading to a rather ill-defined state of "sub health," with an increased susceptibility to any and all infections. Admirable public health organisation has been successful so far in preventing any serious increase in cases of all except venereal disease and tuberculosis. It is the latter which is causing rising concern in the Hospital. The great danger of infection occurs during the first few months of the clinical period, when the student arrives at Guy's for the first time. To minimise the risk the Medical School now, as always, recommends that students should not live close to Guy's where it is possible to arrange otherwise. In pre-war years arrangement was made for all students to be X-rayed, once on entering the Hospital and again after six months' clinical study. A Mantoux test was also done—the whole being covered by a small fee. At the outbreak of war the arrangement broke down and it was not until last October that any effort was effective in reinstating a similar scheme. It seems doubtful whether an examination, after six months' clinical study is a sufficient answer when a period of at least three years must elapse before the student—then qualified—is investigated on entering the Services. The measure is also incomplete in that no provision is made for the group of students who have "missed the boat" on both occasions. However, it is the student's responsibility ultimately to ensure that he avails himself of the facilities of the Hospital, which are all his for the asking.

WE hear, with regret, of the death of Sir Francis Fremantle, who was at Guy's at the end of the last century. An obituary will appear in our next issue.

WE wish to congratulate Mr. Ogilvie on his promotion to the rank of Major-General (acting), A.M.S., news of which was received after the publication of his article in our last issue.

Dyspepsia in the Royal Air Force

By AIR-COMMODORE J. J. CONYBEARE, M.C., D.M., F.R.C.P.
Consultant in Medicine to the Royal Air Force).

(*Reprinted from the R.A.F. "M.T.E. Journal" by kind permission of the Editor.*)

SIZE OF THE PROBLEM.

FOR reasons of security it is not possible to give the total number of personnel in the Royal Air Force who have been invalided for symptoms attributed to abdominal disorders. It may, however, be stated that of the total personnel invalided from the Service each year since the War started, close on 20 per cent. have returned to civil life as a result of gastro-intestinal disease. Of these only a negligible percentage have had disease of the intestines, such as colitis, growths of the colon, or disease of the liver, gall bladder or pancreas and the great majority have been invalided for disease, or supposed disease, of the stomach and duodenum. Needless to say, duodenal ulcer heads the list, with gastric ulcer a bad second. Though gastritis and duodenitis occur commonly as diagnoses on case sheets, they are relatively seldom invaliding disabilities. Other frequent diagnoses are nervous dyspepsia, gastric neurosis, hyperchlorhydria, achlorhydria and sometimes simply dyspepsia, though here again such diagnoses are seldom seen on invaliding boards, mainly because they are unacceptable to the competent medical authorities. Actually, it is not uncommon to find such cases ultimately invalided under the heading of anxiety neurosis, which probably gives a truer appreciation of the situation.

Any attempt at a statistical approach to the problem of dyspepsia in the Service is necessarily difficult. The various Service hospitals draw their patients from widely different types. Thus, some hospitals are mainly dealing with trained aircrew or skilled technical ground staffs. Others are dealing mainly with raw recruits, others with personnel under training of widely varying ages and varying proportions of both sexes.

Moreover, it must be remembered that a high proportion of Air Force personnel are treated and indeed invalided from E.M.S. hospitals, where the standards of what constitutes an invaliding disability vary from hospital to hospital. It is clear, therefore, that it is extremely difficult, if not impossible, to get any comprehensive picture of the problem of dyspepsia or to enforce any definite policy with regard to either the duration and type of treatment, or even the general principles as regards invaliding from the service.

DYSPEPSIA IN CIVIL LIFE AND SERVICE LIFE.

In civil life the vast majority of employed persons who have to be absent from work as a result of illness have to sacrifice many of the amenities of life for themselves and their families. Though they may receive sick pay this is invariably much below that which they receive when at work and a prolonged illness often means real hardship and financial strain, if not to the invalid himself, at any rate to his dependents. There is, therefore, a strong psychological and economic stimulus to avoid invalidism which necessitates absence from work, or, at any rate, to return to employment at the earliest possible moment. In Service life there is not necessarily the same stimulus. Personnel off duty in quarters, sick quarters or hospitals not only continue to draw full pay, but, in many ways, are better off at any rate materially—comfortable beds, well-heated accommodation, better food and no work. Nor are their families and dependents in any way affected. While it is not in any way suggested that malingering or even gross exaggeration of symptoms is common, there can be no doubt that the desire for early recovery and return to work is a less potent stimulus in Service than in civil life.

Moreover, the ever-widening gap between the earnings of civilian and Service personnel is an important factor. A skilled tradesman in the R.A.F. earns only a small amount compared to what he could earn as a civilian. Without there being any conscious attempt at malingering many a serving airman must have subconsciously at the back of his mind the thought of how much better off he would be in civilian life. Not infrequently he persuades himself that he could give better service to his country if he were returned to civilian employment.

Such an attitude of mind is bound to be fostered by hospitalisation, especially among those suffering from various types of dyspepsia. In wards both in Service and E.M.S. hospitals there is often a conglomeration of those undergoing investigation, those with proved or supposedly proved diseases, such as duodenal ulcer, and those who are awaiting return to civil life after boarding. Discussion of symptoms, so common and so unavoidable among patients, especially "gastrics," must necessarily have an adverse effect on morale.

In Service life even apart from hospitalisation there are many other factors which predispose to dyspepsia. Though Service food, particularly in the R.A.F., is probably better both quantitatively and qualitatively than it is in civil life, it provides less scope for personal choice and idiosyncrasies. Not infrequently meals have to be eaten quickly and often irregularly and, whereas most civilians can relax for a period after a meal, this is often impossible in the Service. All of us must be familiar from personal experience with the fact that overwork, fatigue, heavy responsibility, danger and anxiety may interfere with appetite and digestion, so it is not surprising that some persons who have been accustomed perhaps for years to regular and ordered lives should develop dyspepsia when suddenly faced with the very different conditions necessitated by life in a Service. Only too often such patients are transferred to hospital where searching and often alarming investigations, such as test meals, barium meals and even gastroscopy tend to instil into their minds that something must be very radically wrong. Firm but sympathetic handling of such cases by unit medical officers, rather than investigations in hospital, would go a long way towards enabling such patients to adjust themselves to new surroundings.

Unfortunately, too, the exigencies of training in the R.A.F. necessitate frequent transfer from station to station, so that in many cases an airman finds himself under treatment by a succession of medical officers. This sometimes results in a patient suffering from dyspepsia being readmitted to hospital, even though in the recent past he has already been thoroughly investigated.

Other features of Service life may predispose to the development or aggravation of dyspepsia. Thus severance of domestic ties and fears of posting overseas may produce anxiety, which often manifests itself most strikingly in gastric symptoms. Worse still an airman with this type of anxiety may see others whose postings have been cancelled for similar symptoms, sometimes at the last moment, and this tends to produce an exaggeration of symptoms, conscious or unconscious.

THE INVESTIGATION OF PATIENTS WITH DYSPEPSIA.

What is meant by the term " dyspepsia " ? The Oxford Dictionary merely defines it as " indigestion." It must be realised that dyspepsia is only a symptom and may occur in a multitude of disorders, which cover practically the whole field of medicine. Therefore to say that a patient is suffering from dyspepsia tells us practically nothing, and it is the function of the medical officer to discover the underlying cause of the indigestion. This he will attempt to do in the first place by a careful enquiry into the patient's symptoms and by a thorough physical examinatiom. In certain cases this may have to be supplemented by investigations, such as a barium meal, a test meal and examinations of the fæces. With all of these medical personnel who have worked in hospitals are familiar.

It is important, however, to realise that in the majority of cases of dyspepsia the condition is transient and of minor importance. Indiscretion in diet, particularly in the taking of alcohol, over-smoking, a large and hastily eaten meal, perhaps food which has been contaminated by micro-organisms, may all produce indigestion of varying degrees of severity. Mental stress, anxiety over service or domestic affairs, overwork, or lack of sleep may all produce an upset of the nicely regulated mechanism, which is necessary for a good digestion. If such factors can be eliminated or if the individual can adjust himself satisfactorily to his environment his dyspepsia will disappear. Most of us must have had personal experience that digestion and appetite can be upset by purely psychological causes. Thus an unpleasant sight, such as mangled human bodies after a crash, may produce a sensation of sickness or even actual vomiting. Even such minor things as the imminence of *viva-voce* examination may in some people produce loss of appetite, vague indigestion or a tendency to diarrhœa and frequency of micturition.

It is clear, therefore, that many persons who complain of indigestion may have nothing structurally wrong in the stomach, duodenum or alimentary tract and that their symptoms are a purely reflex response to emotion. This type of dyspepsia, often termed nervous indigestion or gastric neurosis, though usually transient, may be of long duration, particularly if the anxieties which have produced it remain undealt with. Only too often such patients with nervous indigestion come to believe that they have something seriously wrong with their internal organs and this, by producing further anxiety, aggravates and perpetuates their symptoms.

Individuals vary in their susceptibility to indigestion. Some have digestions like an ostrich and can without penalty—at any rate, as far as digestion is concerned—get very drunk. In others, the least indiscretion is paid for by a digestive upset which

may make life a misery for some days. Yet in both classes nothing abnormal will be discovered by investigations such as X-rays or test meals. Sometimes a " delicate " digestion may be a family characteristic.

Chronic dyspepsia may also result from a number of underlying conditions, of which, at any rate in personnel of the R.A.F., duodenal ulcer is probably the most common. In addition to this very similar symptoms may be produced by many other causes, such as a gastric ulcer or inflammation of the gall bladder. It is in the detection of underlying organic disease of the abdominal organs that investigations are of value.

In dealing with cases of dyspepsia the medical officer has to make a very important decision. Is he to give the patient some simple remedy such as an alkaline powder and try to encourage him to get well, or is he to refer him to medical specialists and arrange for comprehensive investigations in hospital ? This decision is of great importance because if a patient with minor or nervous indigestion is admitted to hospital and subjected to numerous and searching investigations it is probable that far from improving his dyspepsia it will undermine his morale and aggravate his condition. If, on the other hand, the patient really has an underlying organic condition, such as a duodenal ulcer, his symptoms are unlikely to clear up without prolonged dietetic treatment in hospital.

The responsibility of the unit medical officer is therefore a grave one. He has to deal with each case on its merits after careful individual study. There will necessarily be errors of judgment and some patients will be referred to hospital for investigation unnecessarily and others may have organic lesions, such as a duodenal ulcer, overlooked. Speaking generally, it is probably true to say that more harm is done by the unnecessary transfer of patients to hospital than by retaining them under observation and treatment in their unit. This is specially true of recruits, where change of environment and routine is very likely to produce temporary indigestion, which will clear up spontaneously under the influence of a firm, tactful and experienced medical officer.

The undesirability of hospitalisation in cases of dyspepsia has already been stressed. No patient should be retained in hospital, particularly in a ward filled with " gastric " patients, unless he has a definite lesion, such as an ulcer, for which treatment is required. It should always be possible to arrange for an X-ray of the stomach and duodenum to be done as an out-patient. Test meals only rarely give information of diagnostic value and their routine employment is unnecessary. So far as possible no patient should be admitted to hospital unless there is very good reason for believing him to have organic disease.

The limitations of X-ray examinations of the stomach and duodenum are not always fully understood. Their value depends primarily on the skill and experience of the medical officer who carries out the investigation. Even in the most experienced hands variations in X-ray diagnoses may occur. The absence of an ulcer demonstrable by X-ray does not necessarily mean that no ulcer is present. On the other hand X-ray reports of duodenitis, spasm and irregularity of the duodenal cap often serve only to confuse the issue.

The findings in test meals are only too often taken as an explanation for symptoms. It is not always realised that very high concentrations of hydrochloric acid or its complete absence may occur in persons in perfect health. Much harm is done by telling patients that they secrete too much acid. This and the advertisements of proprietary remedies tend to make them centre their thoughts on their " acidity " sometimes with disastrous results. Patients are even sometimes told that they suffer from hyperchlorhydria or acidity, without a test meal having been performed. Indeed, it is not uncommon to encounter persons who consider themselves to be martyrs to acidity, who with a test meal may be shown to have normal amounts of acid or even none at all.

Though in hospitals it is often convenient from an administrative and dietetic point of view to aggregate all the " gastrics " in one ward, this has the grave disadvantage that it facilitates the discussion of symptoms among the patients and often leads to aggravation and exaggeration of symptoms, each vieing with the other in the wealth and variety of his own abdominal experiences. This can be largely prevented by investigation as an out-patient and by scattering " gastrics " throughout the wards when practicable.

The subject of nervous indigestion has already been discussed. It should be emphasised, however, that even patients with organic lesions such as an ulcer, may and often do have their symptoms much aggravated and perpetuated by a neurosis. As a rule patients with definite ulcers respond to treatment far more rapidly than do those where there is a big neurotic element.

Two Interesting Cases of Death both Consequent upon an Epileptic Fit

By A. CHURTON TAYLOR, Police Surgeon, Portsmouth.

CASE I.

H. L. T. H.; able-bodied seaman, aged twenty-eight. Found dead in his bunk at the R.N. Barracks, Portsmouth, at 7.15 a.m. on October 28th, 1942.

Post-mortem October 29th, 1942, some seventeen hours after death.

Tongue: on the left-hand side there were definite marks of the teeth with bruising. The teeth had produced irregular lacerated wounds. Larynx: froth and mucus present. Lungs: marked bi-lateral congestion with marked œdema. Heart: ante-mortem clot in the pulmonary artery. Stomach: small quantity of food residue identified as partially chipped potatoes. Œsophagus: piece of softened and partially digested chipped potato, about half size of the little finger nail. Thymus: persistent and weighing $1\frac{1}{4}$ oz. All other organs healthy but congested.

Cause of Death:—

1. Shock.
2. Laryngeal spasm and œsophageal spasm consequent upon inhaling the foreign body into the œsophagus and mucus into the larynx.
3. Asphyxia (death was slow, as shown by the ante-mortem clot in pulmonary artery) and marked congestion of all organs.
4. Epileptic fit.

Death was presumed to have taken place during the fit, as shown by the congestion present.

In the coroner's court the following facts came to light:—

Several witnesses who slept in the same bunk as the deceased testified to hearing sounds during the night as if he was dreaming or grunting. They went to sleep again. They had also had supper with him and said that deceased had definitely had a fair amount of chipped potatoes during the course of the evening.

Surgeon-Commander Scott-Forbes, R.N., Medical Officer of the Barracks, who was called to see the deceased and who was also present at the post-mortem produced interesting notes on the case.

His record showed that, on entering into the Royal Navy in 1941, he was perfectly healthy and that there was no family history of epilepsy. He had been under investigation at the Royal Naval Hospital at Philadelphia, U.S.A., from May 28th, 1942, to July 3rd, 1942. Whilst there he had two fits. The electro-encephalogram indicated latent *grand mal*. The fit that caused his death was the only one that he had had in this country.

CASE II.

Mrs. B. H. M., aged twenty-two, was found burnt to death on October 30th, 1942. She was last seen alive about 7.45 a.m. The body was found by her aged father about 9 a.m. The head, neck and upper torso were lying on the open grate. He dragged the body off and ran for help. She had had epileptic fits since she was nine and had been attending St. James' City Mental Hospital for many years. Fits were frequent but getting rather less lately. Duration of fits: Two and a half hours to ten minutes. Last fit before death was seven days ago.

Accurate time of death was impossible owing to extensive charring and scorching that had involved the back of the head, neck, arms and upper torso. Burning had taken place down to the middle of the abdomen. Below this limit the body was warm.

Her husband used to get up and light the fire for her at 8 a.m. before he left for work. He then took her up a cup of tea. The baby—aged twelve months—also had a cup of tea. She usually got downstairs about 8.15 a.m. That puts the length of time she could have been on the fire at about three-quarters of an hour. Accurate time of death impossible owing to the fact that so much destruction had been produced in the upper body by the heat.

Post Mortem 28 hours after death.

External injuries :—

Left side of head and face—including the back of the head (hemi-section)—completely charred down to bone, which was itself charred and showed multiple areas of chipped bone. The hair was burnt off ; the right side of the section was only slightly burnt ; the hair was untouched, but the right eyelid was blackened and burnt on to the globe of the eye.

Left eye and socket completely burnt out, charring taking place into the boney vault of the skull. Left side of the nose was also charred.

Mouth showed second and third degree burns. Marked œdema of the lips. Tongue protruding and firmly fixed between the teeth.

Arms.—Both showed typical " attitude of combat " fixed by the intense heat. Left arm to a right-angle and in front of the face, the right arm lying across the chest. In the mortuary terrific force had to be used to move the arms away from the face whereas the legs could be moved easily with the usual amount of force used to overcome post-mortem rigidity.

Right and left arms : multiple areas of first and second degree burns and marked brown scorching such as is seen if clothes are scorched in front of an electric fire.

Neck : left side and back of neck and upper back charred as the head. The neck could not be rotated in any direction.

Front of chest showed large scattered areas of brown scorching and first and second degree burns. The clothing had been burnt off down to the waist. The destruction was limited by the tight clothing at the level of the mid-abdomen, which was worn at the time of her death. The area of injury to head and neck corresponded with the open grate.

The skull was charred right through to the inner table of the skull. This equalled the external area involved. Two pieces broke off like burnt toast.

Internal Injuries :—

Brain : the underlying area of the brain was also cooked and charred and was found to be burnt on to the inner table of the skull. Remaining portions of the brain were normal and untouched by the heat. The tongue showed indentation of five teeth on the left-hand side.

Larynx was normal. No soot was present in the air passages, showing that there was no naked flame burning to produce asphyxia at the time of death.

Heart was normal as were all her other organs, but showed marked congestion. Stomach was empty. Thymus was persistent (weight 2 oz.).

Cause of Death :—Shock, consequent upon epileptic fit which caused her to fall on to an open grate from which she received severe multiple and fatal burns.

The fact that various degrees of burns were all present at different stages and that they showed the normal reaction to injury, goes to prove that she was alive at the time of falling on to the fire and that she lived for some time afterwards. The fire was fitted with a guard, but she had obviously removed this when she came downstairs. She refused to have anybody permanently in the house during her husband's absence at work.

The thymus was persistent and enlarged in both cases, but there appeared to have been sufficient cause of death found to exclude this organ as the cause thereof.

I should like to express my sincere thanks and appreciation to Mr. A. C. West, Chief Constable of the Portsmouth City Police, for the great interest he has shown in these two cases.

It is regretted that a number of photographs sent to illustrate this article could not be reproduced—they will, however, be on exhibition in the Wills Library for a short time.—ED.

Correspondence

"UNCLE HARRY'S" ADVICE SOUGHT.

We have received the following letter to "Uncle Harry," sent c/o the *Gazette*:—

DEAR UNCLE HARRY,—I hope you will excuse me occupying your valuable time, but I have a proposition to make.

You will remember that my case is a fairly typical one of those who qualified since the War began. An externship, somewhat skimped by evacuation of promising mothers, and special appointments even more skimped by lack of opportunity to practise the arts, due either to a retiring disposition or, more likely, to an inherent laziness and a dislike of pushing through a crowd to look down the earhole of the solitary patient; the "study of the ravages of the staphylococcus on the necks" of the front and second rows was more my forte. However, Finals were undertaken and eventually overcome to the accompaniment of the disturbing orchestra of A.A. guns and celebrated in the late lamented "Ship."

Then a period of six months as a houseman was followed by "bolifaction" by the Services and export to India. Here the sorry scholar saw, treated and evacuated many sepoys with malaria and heat stroke, and was beginning to consider himself a moderately competent doctor in the military circles in which he moved. The awakening came one peaceful afternoon when a captured dacoit's wife began to bleed P.V. (an abortion—missed, I hope). Treatment from Regimental Pannier No. 1 was instituted, fortunately or unfortunately with success. Mental efforts recalled to mind the correct hole in which to insert the pipe; but the opinions of capabilities were revised radically, to be even further revised when the success brought in its train a queue of old men and maidens, wives and children with infant-feeding problems and a rather credulous faith. A silver nitrate stick, some aspirin, some quinine, and some advice to the mothers about the inadvisability of feeding locusts to twenty-day old babies had their palliative value, but floods of half remembered learning came back.

To get down to the onions, therefore, dear Uncle: Before we are released on the suffering public after this war—be it as assistants, general practitioners, or as Ryle's public servants—are any steps to be taken to re-instruct us in what we have forgotten or have never learnt? May we be assured of organised teaching in the diseases and natural processes of children, women and the elderly? My hopes are that such instruction may be given as a form of study leave before demobilisation; for what will we have in the way of cash when we disembark? The ships will have run dry and our pockets will be empty.

Your affectionate nephew,

Indian Field Ambulance,
India Command.

GUY MINIMUS.

"EXTRACT FROM A LETTER RECEIVED FROM SICILY."

"IT'S good to be back in Europe again. The sight of earth, however arid, is refreshing after the sand of the last few months, and although much of our surroundings are squalid, with a standard of hygiene no higher than the Arab, it is European squalor. The Colonel and I have been in Sicily for a week now, very busy; he is in good form and, although at the moment he is away laving the body, I am sure he will wish to be remembered to you and send his salaams. Yesterday I saw Boland, in good form. He said he had had two air-letters from you within a week. I am seeing a lot of Morton-Palmer, and have also run into O'Gorman, James Rink, "Bum" Holden and Trick; it is said that Lindsey and Ogle are about these parts—they were always remembered as a pair at Guy's.

The climate is hot and a bit sticky; flies are a great pest and the mosquito is being troublesome. Children swarm; the women are either too young to be pregnant, too old to be pregnant, or pregnant. The black of catholicism is the predominant colour. Fruit is very plentiful and wine is almost for the taking, which adds some colour to the inevitable bully and biscuit. For a local wine it is good with an equal measure of water; Marsala has not made much of an appearance as yet, but as a fortified wine is probably being held in bottle by the owners until prices stabilise themselves. I have

many good laughs and am becoming an expert at requisitioning houses; the atmosphere is friendly and voluble, with much hand-waving and body contortions at times almost amounting to genuflections. Withal, the politeness is but a mask for ingenuous duplicity; I have at last got used to the red herring of *una bella palazza* just round the corner, quite unoccupied and just what is wanted, for on arriving there the process is bound to be repeated. Nor am I bought off with a bunch of grapes or a handful of almonds, or even a tasteful exhibition of the daughter. We had quite a lot of work to do on the other side of the Mediterranean and life was tolerable, but I am sure this will be better. It was very hot in a tented hospital, and the nearness of the sea was almost a necessity, and certainly a refreshment. We lived a very restricted life as we were isolated without transport. . . ."

Sector News

Guy's Letter

GUY'S has been, and still is, working to capacity. Every ward is full and would overflow if there were anywhere to flow to. Nuffield House is now getting into its stride, so that both the medical and nursing staff have their hands full. The strength of the former has been most unfortunately weakened by sickness, and there have been many changes and substitutions in personnel. We were very lucky at one time, in that Flight-Lieut. Hamilton, R.C.A.F., who was on leave, did a week as H.P. We are very grateful to him for so nobly undertaking a busman's holiday.

The pressure should ease in the next few weeks, for most of the Borough has left for the hopfields, and their sick and injured will presumably descend on the bases direct—over to you, Pembury!

We have not made the proverbial error of "All work . . . .", even if there has been much to do. On the evening of August 25th a swimming gala or splash night was held in the Nurses' Home bath. This was very well supported by competitors and spectators. There were many events, but no one seems to remember who won what, so we must congratulate splashers and splashed together for a most successful evening.

Earlier in the month a dance was run to obtain books for the Navy. This, too, we hear, was a successful party, as it should be, for such a worthy cause. No figures have been published as to the number of volumes achieved, but their subject-matter was very varied. It is to be hoped that there is as much catholicity of taste in the Royal Navy as in Sector 10—and, after all, sailors don't care anyway. D. L. G.

Sayings and Quotations of Sir William Osler

L'Envoi. Remarks at Farewell Dinner given by the profession of the United States and Canada, New York, May 2nd, 1905.

I have made mistakes, but they have been mistakes of the head, not of the heart. I can truly say, and I take upon myself to witness, that in my sojourn among you—

"I have loved no darkness
Sophisticated no truth
Nursed no delusion
Allowed no fear."

Sport

Cricket

Guy's beat St. Mary's on Saturday, August 7th, by 102 runs.

Guy's, 194 (Alderman, 44); St. Mary's, 92 (Alderman, four for 36; Saunders, four for 6).

Garland and Murphy gave Guy's a useful start of 40, but when four wickets had fallen our total was only 80. Alderman and Brown scored rapidly and together put on 70—an invaluable partnership at that stage in the game. Guy's were all out for 194. St. Mary's never seriously tried for the runs. Kemp drove powerfully, so that for a time a draw seemed probable. Happily, however, several good catches were held and we won with thirty minutes to spare. The result was so convincing almost to be disappointing as St. Mary's were reputed the strongest hospital side this season.

Certainly they were without two of their regular players, but then so were we; and Guy's fully justified the gentle celebration which followed.

Team.—E. W. R. Alderman, G. W. Garland, E. G. Murphy, D. C. Boyd, D. R. S. Saunders, A. Brown, R. G. L. Brittain, R. Finney, D. Nicholson, J. Elder, A. G. Ellerker.

Guy's beat Richmond by 71 runs on Saturday, August 14th, at H.O.P.

Guy's batted first on a wicket not quite dry from the night's rain. Against accurate bowling only Murphy really settled down and, after opening, he was last out, having scored exactly 100. It was a fine innings. Guy's total was 209 for 7 (declared).

When Richmond batted the wicket was quite dry, but Alderman managed to make the ball fly a little. Nevertheless, with only half-an-hour left for play, Richmond were 120 for 4. Two of these wickets fell to very fine catches by Saunders, one in particular being most spectacular. At this stage Saunders came on to bowl and, in an inspired spell, took seven wickets for 34, giving Guy's the game. The last wicket fell to a catch in the slips off the last ball in the last over.

Team.—E. W. R. Alderman, G. W. Garland D. C. Boyd, E. G. Murphy, D. R. S. Saunders, L. D. Carton-Kelly, A. Brown, R. Finney, R. G. L. Brittain, J. Elder, A. G. Ellerker.

Against Metropolitan Police on Sunday, August 15th, the match was drawn.

Metropolitan Police, 190 for 8 (declared); Guy's, 112 for 9 (Alderman 40).

This was a sorry anticlimax after yesterday's victory. A good first wicket stand by the Police upset the whole team. Catches were dropped and, taking full advantage, the Police scored the highest total Guy's had yet faced. Our batting was not merely disappointing, it was shameful; in no circumstances is any team justified in playing for a draw from the word go. But Guy's did on this occasion. Alderman redeemed a certain amount of our self-respect; he played a very energetic innings which was especially praiseworthy in view of the fact that he had already bowled sixteen overs, being the only bowler to keep the runs down.

Team.—E. W. R. Alderman, G. W. Garland, D. C. Boyd, D. R. S. Saunders, A. Brown, R. Finney, J. Elder, A. B. Lee, Three Others.

Guy's beat St. Thomas' Hospital on Saturday, August 21st, by 63 runs.

Guy's, 155 for 7 (declared) (Elder, 39 not out); St. Thomas', 92 (Alderman, six for 28).

Guy's seemed in great danger of spoiling their undefeated inter-hospital record when they had lost six wickets for only 54 runs. Most of these early wickets fell to good catches, largely because the batsmen went too wholeheartedly for the runs before playing themselves in. Finney and Elder showed that with a little more respect runs came fast enough, and Thompson put the batsmen completely on top, scoring 35 with some perfectly timed strokes. Guy's declared, leaving St. Thomas' exactly two hours to bat. The latter soon lost two wickets, but never looked like collapsing till their fifth wicket fell. Alderman came on for a final spell and bowled their last man with fifteen minutes to spare.

Team.—E. W. R. Alderman, G. W. Garland E. G. Murphy, D. C. Boyd, D. R. S. Saunders, A. Brown, R. Finney, G. Thompson, D. Nicholson, J. Elder, P. L. Brangwin.

Vegetable Growing at Guy's in the Superintendent's Kitchen and Hospital Strong Room

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

FIRST EXAMINATION FOR MEDICAL DEGREES.

July, 1943.

J. L. Attenborough — A. Levy
A. W. Cook — B. Plant
M. H. Handoll

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.

July, 1943.

Honours.

P. C. Grummitt.

Distinguished in Surgery, Dental Surgery and Operative Dental Surgery.

Pass.

H. C. Martin — A. J. Walters

Supplementary Pass List.

GROUP II.

T. D. Birtwhistle — A. J. Goodwright
J. C. Cox — J. A. Ireland
E. C. Glover

SECOND EXAMINATION IN DENTAL SURGERY.

PART I.

July, 1943.

C. D. Baker — J. B. Kirkwood
R. A. C. Dove

The following Candidates are credited with Anatomy and Physiology :—

July, 1943.

B. M. Bilton — A. Rooms
R. A. Dean — J. S. Rose
A. K. Parsonage — P. G. Shingler

PART II.

July, 1943.

A. J. Brunnen — G. A. Morrant
A. C. Campbell — S. C. J. Pink
*H. S. M. Crabb — A. D. Robinson
A. Ferrari

* Awarded a mark of distinction.

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

July, 1943.

Surgery.—R. K. Haslam.

Pathology, Bacteriology and Forensic Medicine.—C. M. F. Fiducia, *I. D. Henderson, A. M. Rajah.

Midwifery.—P. D. Bryant, E. D. C. Jones, R. A. Leeming, A. M. Rajah.

* Has completed the examination.

FINAL EXAMINATION.

August, 1943.

Surgery.—*A. M. Rajah.

Pathology, Bacteriology and Forensic Medicine.—*J. H. S. Scarlett.

Medicine.—*J. H. S. Scarlett.

Midwifery.—K. R. J. Coates, T. H. Eustace.

* Have completed the examination.

Papers by Guy's Men

Mansie, J. W. Intra-oral prosthesis in Bilateral Harelip and Cleft Palate. *Proc. Roy. Soc. Med.*, 1943, **36**, 483 (Sect. Odontol.).

Matthews, E. Facial Restorations. *Ibid.*, 484.

Wass, S. H. Treatment of Fractures of the Patella. *Med. Pr.*, 1943, **210**, 87.

Rowlett, A. E. A Basis for a New Professional Orientation. *Dent. Mag. Oral Topics*, 1943, **60**, 89.

—— The Tooth Brush and How to Use It. *Brit. Dent. J.*, 1943, **75**, 92.

Cieman, S. Possibilities of Research in Senile Diseases. *Brit. Med. J.*, 1943, ii, 239.

Macintosh, R. R. Self-Inflating Cuff for Endotracheal Tubes. *Brit. Med. J.*, 1943, ii, 234.

Cross, W. G. Gum Tumours in Pregnancy and Gingivitis Gravidarum. *Brit. Dent. J.*, 1943, **75**, 85.

Shaw, Maurice. West London Hospital in the "Blitz." *Med. Pr.*, 1943, **210**, 101.

Change of Address

H. S. Gaussen, M.R.C.S., L.R.C.P., 6, Elm Grove, Exeter. (*Tel.* : 56108.)

Oliver Ive, Captain, R.A.M.C., The Hermitage, Meadvale, Redhill, Surrey.

Ed. M. Mahon, M.R.C.S., L.R.C.P., 3, Spanish Place Mansions, Manchester Square, W.1. (*Tel.* : Welbeck 5627.)

W. N. Mann, Major, R.A.M.C., No. 57 General Hospital, M.E.F.

Prisoners of War

Ian McD. G. Stewart, Captain, R.A.M.C., No. 1434, Stalag XVIII A (Lazarette Spittal), Deutschland.

C. S. Pitt, Captain, R.A.M.C., 135th Field Regiment R.A., Malaya, British Prisoner of War, c/o Japanese Red Cross, Tokio ; or c/o Miss L. Pitt, Balhom Hotel, Paignton, Devon.

Repatriated

Readers will be pleased to hear that Captain Oliver Ive has been repatriated after being a prisoner of war in Italy since March, 1941.

Births

GRIFFITHS.—On August 17th at Ivy House, Devizes, to Joan (née Geddes), wife of Dr. J. A. T. Griffiths—a son (Paul).

Marriage

JONES—THOMAS.—On August, 1943, at Corwen, H. P. Jones to Olive Thomas.

MORTON—RUSSELL.—On July 28th, 1943, at St. George's Parish Church, Edinburgh, Derrick J. Morton to Kathleen Laing Russell.

Deaths

CROSBY.—On March 15th, 1943, Neville Crosby, M.R.C.S., L.R.C.P., of Kenton Road Kenton, Middlesex.

FREMANTLE.—On August 26th, 1943, Sir Francis Ed. Fremantle, O.B.E., M.P., M.D., M.Ch., Bedwell Park, Hatfield, Herts.

MAYNARD.—On August 19th, 1943, at Furnay Bank House, Maresfield, Sussex, Ed. F. Maynard, M.D., M.B., C.M.

PRICE-JONES.—On August 27th, 1943, Cecil Price-Jones, M.B., of The Apple Orchard, Radlett, Herts.

STRINGER.—On July 12th, 1943, at Christchurch, New Zealand, Louis Bruce Stringer, M.R.C.S L.R.C.P.

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

RUMOURS of every type, both harmless and vicious "tittle-tattle," are always current in the Hospital; they are almost inevitable in such a community. In war-time, with its censorship and possibilities of sudden change and violent action, the matter is correspondingly worse—even more prodigious and hair-raising yarns are in circulation. Whilst we hold no brief for rumour-mongers, some of these stories do occasionally appear to be true. One morning recently "it was said" in the *Gazette* office that Italy was signing an armistice, and, behold, the same evening the great news was announced! Subsequent speculations about the strategic developments of the War on the following day were, unfortunately, not at all accurate.

A few days later another interesting story came to our ears—a yarn of very different nature. A well-known writer—one might almost say notorious writer—was supposed to have visited the Hospital's Incident Room one Saturday afternoon; the account was sufficiently concrete to include his signing of the visitors' book. As we had often heard of the Incident Room, but had few clear ideas about its nature (at one time we laboured under the delusion that it was the "nerve centre" of the Hospital A.R.P. organisation) we resolved to investigate further. After many delays we found Mr. Burgess, of the electrical staff, and were taken to the Incident Room in the basement of the blitzed Surgical Block.

Here there is much to interest all Guy's men and women—especially those who were spared the ordeal of witnessing the Hospital "taking it" during the 1940–41 "blitzes." Every incident is recorded in the log-book down to the last incendiary falling on the premises; there are numerous "trophies," fire-bombs, pieces of land-mine parachute and massive chunks of delayed action bombs—all "acquired" in the Hospital or its immediate vicinity. In the more quiet times since 1941 many people have visited the Room and its visitors' book shows many well-known names. Here was one of the reasons for our quest—G. Bernard Shaw, in large and heavy scrawl.

Apparently Mr. Burgess entertained Mr. Shaw for some time, showing him round and telling him of the stresses and strains of the Hospital in those troubled days. "G. B. S" was keenly interested, amazed to hear that Guy's had taken such punishment, and paid tribute to the courage of the staff in carrying on the Hospital's work at such times.

THE Chartered Society of Massage and Medical Gymnastics holds its Annual Congress on the 24th and 25th of this month. A number of well-known physicians and surgeons are to lecture and address the meetings. It is to be hoped that a number of people will be able to find time to attend; the average student is grossly ignorant of the elements of physiotherapy. How many students are directed to write up patients for "massage" or "heat and exercises," with no idea what this really means and very little idea why it is ordered? Yet this is a most effective branch of therapeutics; apart from major work—for example, fractures and orthopædics, where results are so largely dependent on massage and exercises—so many minor complaints yield to this form of treatment. The minor aches and strains which, though trivial, are often incapacitating to young and old, are often cleared up by heat and massage. The doctor should know more about this useful therapeutic weapon.

OUR congratulations are due to the Cricket XI on one of the most successful seasons for many years. A detailed list of results and averages is not yet ready, but we understand that they have won all their inter-hospital matches, except one that was drawn. We hope the Rugger XV will have similar fortune in the club's centenary season. This starts on September 25th with a Guy's Past *v.* Present match at Honor Oak Park. Owing to service conditions several Past players are not definitely available and further volunteers would be welcomed. Any old Guy's players able to play are invited to communicate with Mr. George Winston.

WE regret to announce that owing to unforseen delay the obituary for Sir Francis Fremantle was received too late for publication. It will appear in our next issue.

Acute Appendicitis

A Clinical Lecture delivered at Guy's Hospital by E. G. SLESINGER, M.S.

GENTLEMEN,—I have chosen the subject of acute appendicitis for my lecture to-day because, although it is such a common condition, you will find as time goes on it will present you with more problems, lead you into more mistakes, and be responsible for more worry than almost any other surgical condition. No age is exempt from the risks of acute appendicitis and, although it is commonest from ten to thirty, very acute attacks may occur in younger children, and I have both operated for it and failed to recognise it in patients of over ninety. Infection may reach the appendix from the lumen of the cæcum or from the blood stream, and in either case septic foci in the mouth and naso-pharynx are of undoubted importance. In children particularly recurrent attacks of tonsillitis are often followed by an attack of appendicitis. Congenital and acquired abnormalities are also important ætiological factors, variations in the amount of lymphoid tissue in the wall of the appendix and therefore in the lumen being of special significance. It is important in connection with symptoms to remember that the appendix is very variable in its position. It may be in any of eight positions, which in approximate order of frequency are :—(1) Into the pelvis ; (2) related to the iliac vessels; (3) towards the sacral promontory; (4) posterior to the cæcum ; (5) lateral to the cæcum, within Jackson's membrane ; (6) beneath the terminal ileum ; (7) into the iliac fossa ; (8) mesial to the cæcum. Acquired abnormalities are usually adhesions or kinks resulting from previous attacks of inflammation either within itself or in neighbouring organs. Foreign bodies rarely cause appendicitis, although shot, worms, fruit pips, etc., are sometimes found in it. The so-called appendicular concretion is not a foreign body ; it is a mass of inspissated mucus and fæces, and it is common to find the lumen obstructed by such a concretion with the tissues distal inflamed or even gangrenous, while those on the proximal side are normal. Bacteriologically the B.C.C. is the usual organism found, but this may be because that organism so readily overgrows others, and Haim and other workers have produced evidence to suggest that the streptococcus may, in fact, be the most frequent infecting organism.

Pathology.—When we consider the pathological changes resulting from appendicitis it is necessary to note the reactions of the surrounding peritoneum as well as the changes in the appendix itself, as these have bearings on symptomatology, treatment and prognosis. In the appendix itself the changes are variable. In catarrhal appendicitis the mucosa and submucosa alone are affected, but in the commoner diffuse type all the coats are involved ; the whole organ is rigid, hyperæmic and swollen and the mucous membrane is often ulcerated. Later the lumen becomes filled with pus, and, if there is obstruction and the invading organism is of low virulence, an empyema will result. Perforation, sometimes with extrusion of a concretion, is liable to take place at any stage, leading either to localised abscess or generalised peritonitis, depending on the speed of the process and on the ability of the peritoneal reaction to wall in the infection. If the lumen is blocked by concretion or scar acute appendicular obstruction results, and tension within the lumen leads to thrombosis of its vessels and to rapid gangrene and perforation. The reactions of the peritoneum to inflammation in the appendix are varied and important. One remarkable thing is the constancy with which the great omentum migrates to the area. Although this migration is, so far as I know, unexplained, it is undoubtedly the reason why so relatively few cases of appendicitis lead to generalised peritonitis. In some cases the peritoneal response takes the form of an outpouring of fluid and, in others, particularly where the appendix is retrocæcal, there may be a fibrinous exudate which rapidly mats together the appendix cæcum and adjoining ileum. To such a mass the term " phlegmon " of the appendix is applied, and it calls for a line of treatment of its own. In mild cases resolution may occur, but the appendix will mostly retain kinks or narrowing of its lumen, either of which will render it more liable to another attack. If perforation or abscess formation occur and operation is not undertaken, spreading peritonitis will result, though an abscess may drain itself into the bowel or at times point at the umbilicus. If perforation or gangrene occurs before the formation of protective adhesions, the result will be a generalised peritonitis. An occasional and often fatal result of appendicitis may be the spread of infection along the mesenteric veins with a resultant suppurative pylephlebitis.

Symptoms.—Acute appendicitis presents a remarkable variety of clinical pictures. This is not altogether surprising considering the different positions the appendix may occupy, and the different changes which may occur in it. The so-called typical case is a common variety and is readily recognised; often, indeed, by the patient. The very familiarity of such a typical case is, however, in itself a danger, since it leads to a lack of recognition of types of the disease not conforming to pattern, and one may, perhaps, coin the aphorism that the fact that appendicitis is so readily recognised leads to its being so often missed. The signs and symptoms of an attack of appendicitis are pain, local signs, pyrexia, change in pulse rate, gastro-intestinal disturbance and leucocytosis. The pain of acute appendicitis starts suddenly and increases quickly, giving rise to characteristic cramp-like exacerbations. At first it is often in the epigastrium or over the umbilicus, but in an hour or so it shifts to the right iliac fossa. In the obstructive type colicky pains mark the onset, without change in temperature or pulse rate, and continue until operation is undertaken or perforation results. Cessation of the cramp-like pain of appendicitis may be due to rupture or gangrene. If it is the former, generalised abdominal pain follows in a few hours, and if the latter gradually increasing local tenderness occurs. The important point is that sudden cessation of pain is never a sign of recovery, but is always grave. Recovery when it takes place is a gradual and not a sudden process. In gangrenous cases, especially in children, the pain throughout may be slight, but in no case can the severity of the lesion be measured by the severity of the pain.

Local Signs.—On inspection the lower abdomen may be seen to move less freely than the upper on deep respiration, and the right half less than the left. Tenderness and local muscular rigidity are present over the site of the appendix, and this is probably the most important single sign in acute appendicitis. Tenderness and rigidity in certain cases are greatest over McBurney's point, which is a point at the junction of the middle and outer thirds of a line joining the umbilicus to the anterior superior spine of the ilium. I cannot impress on you too strongly that this localisation at McBurney's point only occurs in certain positions of the appendix, and that absence of this sign in no way excludes the diagnosis. If the appendix is retrocæcal the maximum tenderness and spasm are posterior, and if the appendix is long and pelvic in position there may be no abdominal tenderness and spasm at all, and it is only on a rectal examination that an acutely tender point is found and sometimes a mass is felt. Guy's men are sometimes chaffed on the importance attached here to rectal examinations, but I can assure you that routine rectal examination results in many a case of acute appendicitis being recognised which would otherwise have been missed. If a case is seen late in an attack there may be a mass in the right iliac fossa. If there is rigidity over the mass it is probably an abscess, while if there is not it is probably a phlegmon—that is, a mass of adherent coils of gut and omentum round an inflamed or perforated appendix. Pyrexia is almost always present in some degree at some time during the attack, except in cases of the obstructive group. It is seldom high, often only 99 or 100, but its presence may be the deciding factor in diagnosis from a simple colic. I have seen rigors at the onset, although they are very rare, and mean that the appendix lies in relation to the iliac vessels or the ureter.

The pulse rate is usually increased and gets faster as the attack progresses. Perforation quickly increases the rate and a pulse of 120 or over is very suggestive of such an event having occurred. Gastro-intestinal disturbances are almost invariably present. The tongue, clean at first, becomes furred and dry as peritonitis develops. Vomiting is frequent. The vomiting is usually at the onset of the attack, and in the obstructive type of case it continues, indeed the continuance of vomiting is a strong point in favour of the diagnosis of this type of lesion. In the inflammatory type vomiting passes off, but nausea and distaste for food persist. Constipation is usual and in many cases is absolute. Diarrhœa is by no means uncommon and usually indicates a pelvic position of the appendix, in which case it is often associated with some frequency of micturition. Absence of the usual sounds on auscultation over the ileo-cæcal region is a helpful sign usually meaning that the inflammation is spreading beyond the confines of the appendix. Leucocytosis occurs in most cases, though in the fulminant gangrenous ones there may be none. In range it varies from twelve to twenty thousand, the increase being a polymorphonuclear one, with a number of immature forms. It is not often of much diagnostic help, but in an occasional case may just tip the scales of evidence.

Diagnosis.—Appendicitis must always be thought of in the diagnosis of any acute abdominal disease. It is the commonest acute inflammatory condition occurring in the abdomen, and I think students are apt to forget that the common things do in fact

occur most commonly. As I have said, the average case is recognised without difficulty, but it is important to remember that one positive sign is worth several negative ones. Tenderness on pressure in the iliac fossa or through the wall of the rectum is the most constant single sign, and in its presence most careful watching is necessary before a diagnosis of acute appendicitis can be safely discarded. A general examination is, of course, essential to exclude conditions which, as we shall see, sometimes lead to mistakes, and it is well to remember that an inflamed Meckel's diverticulum will give signs identical with those of appendicitis. If at operation the appearance of the appendix does not accord with the clinical picture, a Meckel's diverticulum should always be looked for.

Differential Diagnosis.—The conditions likely to give rise to a mistaken diagnosis are both intra-and extra-abdominal. Of the latter pneumonia and diaphragmatic pleurisy are the most common causes of error. Psoas abscess, lead colic and the abdominal crises of tabes are classical sources of mistakes in diagnosis, but, provided the possibility of their occurrence is kept in mind, they can generally be recognised without much difficulty. In the case of other intra-abdominal conditions, however, mistakes are much more likely to occur. Regional ileitis, during its acute stage, is very difficult to distinguish. The history is longer, the tenderness is less localised, and sometimes an indefinite tumour can be palpated, but in many instances the condition can only be recognised with certainty at a laparotomy. Several of the uretero-renal diseases often give rise to difficulty, and especially perhaps pyelitis. A characteristic tenderness in the costo-vertebral angle, the higher level of the pyrexia and the frequent occurrence of rigors, which are rare in appendicitis are helpful points, but in those cases where the urine remains normal for some time—and such cases are not very rare—the difficulty may be a very real one. Ureteral calculus and intermittent hydronephrosis can usually be recognised by careful examination of the urinary system. In women, tubo-ovarian disease is a great source of difficulty. In some cases appendicitis co-exists as a result of the spread of infection and, if after a careful pelvic examination, doubt still exists it is far safer to operate than to risk leaving an acute appendicitis alone. I have often seen rupture of a Graafian cyst or a corpus luteum lead to operation for appendicitis, and I know of no way of avoiding this mistake at times. Perforations of gastric or duodenal ulcers are not usually difficult to recognise, the degree of general shock, the more widespread and board-like rigidity and the radiation of the pain being characteristic. One of the greatest dangers is the so-called gastric influenza. During epidemics of that disease there are often many patients with an abdominal syndrome, and it is only too easy for the overworked doctor in the rush of work to omit a careful examination of the abdomen, and to find to his dismay that he has missed a case of acute appendicitis with all that that may mean to the safety of his patient and to his own reputation.

Course. Operation should, as a rule, cut short the course of acute appendicitis, but if for any reason it is not or cannot be undertaken it is important to know something about the natural history of the disease. The case may progress in one of three possible ways. Gradual resolution may occur and is most likely in a first attack. Improvement begins on the third or fourth day and is always gradual. Sudden remission always means either peritonitis or gangrene, or else a mistaken diagnosis. In a second type of case the local symptoms instead of improving become steadily worse. The temperature assumes a swinging type and the patient begins to sweat, to lose weight and may have rigors. Gradually a lump becomes palpable, with local muscle spasm over it and often with œdema of the superficial tissues. This, of course, represents the formation of an abscess, which often contains a remarkable amount of very foul-smelling pus. If left to itself such an abscess may rupture into the general peritoneal cavity; it may drain into the rectum or some other part of the bowel; or it may even rupture on to the surface, usually in the region of the umbilicus. Occasionally, in the type of case where the peritoneal response has been fibrinous, a more easily defined and palpated mass develops. The temperature, instead of rising, settles, and the leucocytosis is much less than that usually found with an abscess. This is the so-called phlegmon of the appendix, representing a mass of adherent bowel and omentum round the appendix. Surgical intervention in this type is both unnecessary and dangerous. Left alone, the mass gradually resolves and the appendix can be removed later with safety and ease. The third and most serious course is the onset of generalised peritonitis. This may arise in three ways—firstly, following perforation or gangrene before adhesions have had time to form; secondly, by the passage of organisms through the wall of the intact inflamed appendix, where the peritoneal response is poor or the organisms very virulent; and, thirdly, by the rupture of an abscess into the general peritoneal cavity.

I do not propose to-day to discuss the immediate or late complications of acute apendicitis, although they are many and often very serious, but I do want to say something on the question of treatment.

Treatment.—The mortality in acute appendicitis operated on by a competent surgeon within thirty-six hours of the onset is almost negligible. Since there is no known means by which the course that any particular case is going to take can be predicted, there can, I think, be no possible doubt that once the diagnosis has been definitely established, operation should be advised and undertaken at once. Further, I cannot emphasise too strongly that the use of opiates or purges at the beginning of an attack, or of any illness even suspected of being appendicitis, is quite unjustifiable. There are some who hold that if the case is not seen until later than forty-eight hours after the onset, and if the symptoms are not then progressively getting worse, conservative treatment should be adopted and the appendix removed during the subsequent quiescent period. In the hands of an experienced surgeon, operation in such cases is little more difficult or dangerous than in the early case and, by advising it, the patient is saved from two periods of disability instead of one. If operation is impossible because of the condition of the patient, or of his surroundings, or because of his refusal to submit to it, absolute rest both of body, mind and intestine is the object to be aimed at. The patient is nursed in the Fowler position ; is allowed nothing but water by the mouth ; and is given morphia in adequate amounts and often enough to secure mental, physical and abdominal tranquillity. Under no circumstances should any kind of purge be given. If there is distension, which is not usual, it is best relieved by passing a duodenal tube and applying continuous or intermittent suction. If this method has to be used it should be accompanied by an intravenous drip to maintain the fluid balance. If an abscess forms it must be drained. Whether the appendix can be safely removed at the same time or not depends mainly on the experience of the operator, but it is always safer to leave it than to persist in an attempt to remove it. In the case with a phlegmon the patient should be watched until either the lump disappears or a point of softening indicates that there is pus which can be safely evacuated. Where conservative treatment is being adopted, and particularly where there is any evidence of spreading peritonitis, a course of sulphathiazol should be given, though I do not think there is any indication for using the sulphonamide drugs as a routine.

The *prognosis* of acute appendicitis varies directly with the time that has elapsed since the onset, and it is therefore of great importance to make an early diagnosis and also to see that the making of a diagnosis is followed by rapid action. One attack predisposes to others, the severity of which cannot be foretold, and therefore a patient who has had one definite attack is usually well advised to have his appendix removed at a convenient interval and so forestall the danger of further attacks. The prognosis of a spreading peritonitis is bad, though not quite so bad since the introduction of the sulphonamides as it used to be. Nevertheless, it is sufficiently grave for no one to accept with equanimity the responsibility of withholding operation either deliberately, or by failing to make the diagnosis, from the early case.

Clear Speech

By H. ST. JOHN RUMSEY, M.A.

DR. P. B. BALLARD, late Divisional Inspector of Schools to the L.C.C., in a foreword to a recent book on speech training, wrote that, at one time, a third of the London school teachers suffered from laryngitis or clergyman's sore throat. Here, then, is a definite fact, that incorrect use of the voice results in serious loss of time. Just how valuable that lost time is must depend on each individual case, but very few people make the mistake of underestimating their own importance and the value of their time !

A schoolmaster (I write from personal experience long ago) with laryngitis is a curse to his headmaster even if a joy to his form who are told to " revise," a welcome lull in scholastic activities and often a euphemism for ascertaining cricket averages or stamp swopping.

The reputation of a doctor depends, first, on the reliability of his advice, but hardly less on the clearness with which it is spoken. The doctor who gives his advice clearly in an authoritative voice is likely to have it carefully carried out, whereas equally good

advice, if gabbled in a diffident undertone, will probably be ignored. So the doctor who gives good advice badly is probably no better off than the one who gives poor advice. Further, most doctors must expect to serve on committees and they owe it to their profession and education to do themselves justice by speaking clearly and convincingly.

In Victorian times it was believed that audibility was increased by exaggerated articulation of the consonants and so persistent is a delusion of this kind that elocutionists still *collect* (I will not say *earn*) considerable incomes in return for imparting a stilted and unmusical style of speech. Before the War £25,000 per annum was collected in elocution examination fees alone. It is difficult to estimate the money wasted in learning how to speak badly !

The foundation stone of clear speech is a correctly produced and resonant voice. If anyone is in any doubt about the accuracy of this statement let him think for a moment of the speech of Howard Marshall. The outstanding characteristics are a full, resonant voice, a very steady speed, clear vowels and a good swinging rhythm. Note too, that his consonants are never stressed, and I cannot believe that anyone can have anything but good to say of his way of speaking, while thousands must be grateful for being able at long last to hear and understand the Middle East commentaries. What Howard Marshall does naturally (he has never had a lesson in public speaking) anyone with normal musical perception who is willing to take a little trouble can learn to do.

The foundation of clear speech, then, is a correctly produced voice. It is not easy to try to describe sound in words, but some general advice should help. Like the golf club *the larynx must be allowed to do its own work.* The voice should be produced without any effort and a fair indication that this is being done is the vibration of the breastbone ; if this is vibrating freely the voice production is fairly correct and the constriction of the muscles in the throat and neck which hinders good production and resonance is being overcome. The limitation of effort to the essential muscles is not as easy as it sounds, but it can be learnt.

Every athlete knows how easy it is to make an effort in the wrong way. The golfer must learn to swing instead of " press." Good " timing " in cricket is easy to recognise, but is apt to be elusive when it comes to execution. Pianists know how difficult it is to limit the effort to the muscles that are essential to tone production. In the case of voice production the difficulty is increased by the fact that we do not hear our voices as others hear them and, to the speaker, a constricted tone may sound better than a correctly produced one. It is therefore wise to invite the criticism of some one with experience and knowledge. Remember you have only one larynx, so the *quality* of voice that you use in song should be similar to the *quality* of your voice in speech. *Sing as you speak* and *speak as you sing* are excellent rules. Good singing and good speech depend on a correct balance between voice production in the larynx and word formation with the mouth. Singers are apt to " drown " their words with too much voice, while speakers are apt to " strangle " their voices by over-articulation of words.

Now we come to the second factor of good speech—a steady pace. The amount of time wasted in saying, " I can't hear you," " What ? " or " Eh ? " according to our old school-ties, provides ample evidence of the prevalence of slovenly speech. The vast majority speak too fast. There are three standards of speed ; first—good—slowly enough to be heard without effort ; second—better—slowly enough to be heard so easily that we can be understood ; third—best—slowly enough to be so easily understood that what we say can be remembered. So if you feel that your advice is worth remembering, give it in such a manner that your patient has a reasonable chance of doing so.

Then comes the question of clear vowels and we are at once met by a difficulty. The school-book writers, bless 'em, tell you there are five vowels. The teachers of shorthand tell you of thirteen, but the correct answer is not as you might think—a lemon—but twenty-three. The clear and distinctive sounding of these vowels plays a much bigger part in achieving audibility than stressed consonants.

Rhythm is difficult to describe in words, but those of us who for our pleasure or pain dabbled in the gentle art of writing Latin verses will be familiar with the swinging rhythm of the hexameter. Used originally in Greek it has been copied through the ages by the Latin, German and English-speaking writers. Anyone who is interested in rhythm and wants to develop it might do worse than read Longfellow's hexameters. Even those who cannot appreciate the value and increased audibility resulting from a good rhythm must have experienced often the strain of trying to follow the conver-

sation of someone who uses a poor rhythm either by misplacing the accents (as nearly all Frenchmen do) or by the almost total absence of accent caused by making all the syllables of equal value—very monotonous and tiring !

Lastly, we come to two very important arguments in favour of using a well-developed and controlled vocal tone. *As long as the voice is under control a stammer is impossible.* Whatever people may say of the causes of stammering, and many who ought to know better have made very foolish statements, the fact remains that *control of the voice makes a stammer impossible.* Everyone knows that stammerers can sing without difficulty ! The explanation is very simple ; while singing the voice is under control of the mental picture of the vocal tone and pitch required. If the same is applied to speech and the voice is controlled by a mental picture of the vocal tone and rhythm of the sentence, the words will not present any more difficulty than they do in song. The mouth positions required to form words are identical in speech and song, so what is easy in one is equally easy in the other *as long as voice production in the larynx takes precedence over word formation in the mouth.* As a former stammerer, self corrected, I write from personal experience, I am not quoting the findings of theorists. A stammer may well be described as a " vocal skid " ; it is always in the voice and, when this is under control, it cannot occur.

There is, too, the psychological value of using a full, confident tone of voice. This fact has been overlooked except by the few who have had opportunities of noting what can be done in this direction. Control of the voice not only prevents a stammer, but suggests to the stammerer the confidence which he has lost through past failures. Nor is this increase in confidence limited to stammerers. Everyone who wishes to increase his self-confidence should give his attention to voice production and control. A firm, well produced voice cannot fail to inspire confidence in the speaker as well as in his audience.

Some Experiences of Nursing in India

By MISS N. P. BAMPTON, S.R.N., S.C.M.,
Matron, Q.A.I.M.N.S.

NURSING in India is a very different problem from nursing at home ; it is difficult to get equipment for some of the smaller hospitals—*i.e.*, third class—and I have often thought that Florence Nightingale would probably be more at home than the young sister newly fledged from her well-equipped training school.

Until fairly recently the Indian ward servants wore coloured shoulder tabs to indicate whether they were ward boys, sweepers or water-carriers ; now that this has been done away with, it makes things even more puzzling.

The first hospital I served in was the third class variety and therefore had only one " operating room." It had a nice fire-place, a fire-screen of casement cloth, on which the anæsthetist hung his coat ; the instruments were of a weird and wonderful variety. We had an emergency appendix one day ; the steriliser in which we boiled the instruments was heated by methylated burners and stood on legs. Every time the lid was taken off one or other end collapsed ; progress was slow. In the middle of the operation it became very dark and a dust storm started ; suddenly, with a fearful noise, a pigeon arrived down the chimney covered with soot and dust, flew round the theatre twice and then settled on the screen, where it rested, cooing softly to itself for the rest of the operation. Nevertheless there was a great deal of satisfaction in overcoming the apparently unsurmountable difficulties that presented themselves, and the patients *were* nursed and were happy.

On two occasions a kite swooped along an outside verandah when a meal was being served and flew off with a cup in its talons. I regret to say that this true explanation was not accepted when the accidental went in. Very few hospitals, until recently, had any means of heating or making extra feeds other than over a *sigree*, which is a charcoal brazier. The Indian is, of course, most skilled at keeping the embers glowing, but the orderly is not quite as good, and many a precious chart-case has been requisitioned to fan the embers of a reluctant *sigree*.

Until the war our nursing was done by regimental orderlies. All first-class hospitals had a nucleus of R.A.M.C. The orderlies came in batches every six months ; they

were, unfortunately, mostly press men, though some were undoubtedly good. When the War broke out the regiments recalled all their men, the trained R.A.M.C. vanished to unknown destinations, and we were left high and dry with barely an orderly per ward, so it was decided to draw on the material the country had to offer. Thus the Anglo-Indian section of the R.A.M.C. was born.

Eight hospitals were deputed to train them in batches of twenty-five. With six weeks' intensive training before entering the wards, I had the training of the first six batches; they had an hour's lecture and demonstration in elementary nursing every day, and I found that, whenever possible, the demonstrations were assimilated much better than the lectures. The first four batches were very good, mostly university lads, eager and intelligent, and I got some creditable results. I met several of them two years later, and they had all done well. Then we started to get a very different type; quite a large percentage stated to be Anglo-Indians were really Indian Christians and had a very limited vocabulary in English. Lecturing became most difficult and the simplest request was misconstrued. An exasperated Sister was heard to say to a particularly stupid orderly: "You haven't got an ounce of grey matter, have you?" To her surprise he turned smartly round and went to the medicine cupboard, where he was seen carefully searching. Sister stood it for a few minutes, then said: "And what are you doing now?" He replied in very sing-song English: "Looking for the grey stuff you said you wanted."

Fortunately at this time an Auxiliary Nursing Service was started into which the then V.A.Ds. were co-opted, but new members had to serve three months in a civil hospital before being drafted to us. They were very useful and teachable.

All the bigger hospitals had to supply Sisters at short notice for urgent calls to outstations. Two of us were sent right up into tribal territory during the Mahmoud show in 1931 to nurse a very sick officer who was unable to be moved. He had a perforated gangrenous appendix and peritonitis, and the Indian surgeon from Bannu had brought his own theatre staff and operated as no time could be lost. Our car was guarded fore and aft by frontier constabulary, and at intervals they would stop at an outpost and 'phone, to know if our patient was still alive. We motored sixty-two miles from the railhead, through typical barren rock-strewn country. Our destination was a camp which was one and a quarter miles of dusty land surrounded by double wire . . . . there was one tree.

One of us was on night duty and one on day duty. Our patient was six feet two inches, practically moribund and developed every complication that the text-book described, including bursting his stitches on the tenth day. We had no one to help us lift or bed-make other than a very raw Indian orderly whose ears shut tight the second he heard English spoken, so we used sign language, but we never got him to lift properly. We had no equipment to work with. The M.T. repair shop made us an air-ring by cutting a motor-cycle inner tube and revulcanising it to size. He refused to be parted from this trophy even after he was well. By laying him on the floor of the ambulance on his mattress we were able, after a month, to bring him down to civilisation, resting a week at Bannu and a week at Kohat on the way and eventually to Rawalpindi to convalesce.

It is wisest to know a smattering of Hindustani, as in many stations the servants do not speak English; even a few words gives them confidence and they are usually far quicker to learn than we are.

Correspondence

"UNCLE HARRY" REPLIES TO "GUY *MINIMUS*."

MY DEAR GUY *MINIMUS*,—I will try and put the probable post-war situation before you as briefly as possible.

A certain number of permanent Commissions will be awarded to men who have served. The first question to ask yourself therefore is, "Do I want to make the Service a career or do I want to get out of it?" If you feel you want to take a permanent commission, you must make sure whether you want to do so largely for the social opportunities it offers or whether you really wish to do scientific medicine. I may say that if the latter, the Services—apart from "teaching hospitals"—can offer you unrivalled opportunities.

Should you decide to accept a permanent commission, I would next advise you to specialise, for which purpose you will get ample study leave. There is Medicine, Surgery, Pathology, Sanitation, E.N. and T., Eyes, X-rays, Gynæcology, Physio-therapeutics, etc., any one of which will be useful in practice when you retire. Take a higher qualification.

If you want to go back into civil life when the War is over, you may still be able to specialise while you are serving, which will be all to the good if you go into practice. This depends on yourself.

Whether opportunities for revision will be provided by the Service is a moot point at present. If they are, they will probably comprise a post-graduate course at a teaching hospital, but if you are not in a tearing hurry I would advise, in addition, another house job at a good general hospital, followed by at least six months as an assistant in a good class practice. This will teach you something of the inner working of a practice, together with a knowledge of medical accountancy and record keeping. If you are not an expert dispenser it will also give you a practical introduction—provided your principal is not a man who works entirely with stock mixtures labelled " by diseases "—*e.g.*, " Mist. Bronch.", " Mist. Dyspep.", " Mist. Cathart.", etc., and treats diseases by the appropriate mixture.

My own view is that you can be assured of *nothing* at this stage of the War. If you are sensible you will not drop your reading. There is marvellous scope for work in India, especially eyes. By the way, do the sweepers still search their staple commodity for quin. sulph. pills which have made the passage undamaged ? And do they still sell them second-hand at bargain prices ?

If there is anything else you want to know do not hesitate to ask. Your Cousin Dorothy—W.A.A.F.—is expected back from Washington this month after nearly three years.

Your affectionate,

September 7th, 1943. " UNCLE HARRY."

P.S.—Are you another member of " the family " with a girl in view ? And do you want to get married directly you come out of the Service ? This may largely determine your future. Remember *Punch's* advice.

TO DENTAL STUDENTS.

To the Editor of the GAZETTE.

SIR,—The hum of reconstruction has given place to the guffaw of young voices and to the drone of dynamic labour constructing anatomically articulated full uppers and lowers (not to mention saddle uppers, 6's to the gum, and wire lowers Classes A and B *galore* !) in the Mechanics Laboratory of the Prosthetic Department of the Dental School.

I draw the attention of the new fledglings who have just arrived from the *Royal* Borough to *the* Borough to my first letter to dental students in the *Gazette* of June 12th of this year.

No answers were received to this letter and the presumption that lethargy and apathy are the causes of the decay so rapidly taking hold on the *esprit-de-corps* that once possessed students and staff is, unfortunately, the obvious deduction.

From what I hear the men who have just come to us are not too lethargic and listless, but imbued with a little enthusiasm. It is to these men that we look ; nay, we appeal again for their own good to support *their* Dental Society and to support *their* British Dental Students' Association.

Ideals are rarely attainable, but we need not let this deter and force us to behave like the unfortunate individual who has lost both hearing and sight. Students have eyes and ears and can both hear and read of how the dental profession is disunited and disorganised.

They should intelligently apply themselves to dentistry. It is to the students now in the " Lab." that I appeal to carry the torch that only *just* flickers.

Yours, etc.,

Guy's Hospital, S.E.1. " SYNOPTIC."

DENTAL NURSING.

To the Editor of the GAZETTE.

SIR,—Mr. Stanley's letter relating to State Registered Dental Nurses is quite stimulating. That a need exists for nurses specially trained in dental nursing is increasingly obvious. I would refer your readers to an article by M. M. Loretz, L.D.S. (Eng.), in the *British Dental Journal*, Vol. LXXV, No. 2, July 16th, 1943: A Plea for the Employment of the Trained Dental Nurse.

The question whether Guy's is able to institute a course in dental nursing for the purpose of training young women to qualify as assistants to dental practitioners is only to be decided by the "directors" of our schools' policy—governors, staff and, to a negligible extent, students.

As a matter of interest to our readers, in the University of Toronto, Faculty of Dentistry, such a course was taken over in 1925 from the Royal College of Dental Surgeons of Ontario, who established it in 1919. A dental nursing diploma has been awarded continuously since 1919. The R.C.S. Ontario Dental Diploma until 1936 and the Toronto University Dental Diploma from that date.

The tuition fee is 120 dollars, plus a few odd dollars for athletic club, locker deposits and for the final diploma.

The course covers one academic year (about eight and one-half months); it is of a practical nature and much time is spent in the laboratories of the various departments.

The curriculum incorporates:—Accounting principles; art in a dental surgery; bacteriology (elementary); ceramics; correspondence and business practice; dental anatomy; dental bibliography; dental surgery assistance; ethics and jurisprudence; first aid; hospital dental service; hygiene; operative dentistry assistance and clinical records; oral hygiene and preventive dentistry; orthodontia assistance; peridontia assistance; prosthodontia assistance; radiography; school dental service; typewriting. In the school alone over one thousand hours' work, lectures, laboratory work and clinical assignments are undertaken.

Should Guy's emulate such a course then we would truly be pioneers in dental nurse training in Great Britain.

Yours, etc.,

Guy's Hospital, S.E.1. CYRIL DAVID BAKER.

Sayings and Quotations of Sir William Osler

Teaching and Thinking, McGill Medical School, October 1st, 1894—

There is so much uncertainty and discord even among the best authorities (upon non-essentials, it is true) that I always feel the force of a well-known stanza in "Rabbi Ben Ezra"—

> "Now, who shall arbitrate?
> Ten men love what I hate,
> Shun what I follow, slight what I receive;
> Ten, who in ears and eyes
> Match me: we all surmise,
> They this thing, and I that: what shall my soul believe."

* * * * * *

Everywhere the old order changeth, and happy those who can change with it. Like the defeated gods in Keats's "Hyperion," too many unable to receive the balm of the truth, resent the wise words of Oceanus (which I quoted here with different feelings some eighteen years ago in an introductory lecture)—

> "So on our heels a fresh perfection treads,
> . . . . born of us
> And fated to excel us."

After Twenty-five Years, McGill College, Montreal, 1899.

At corresponding periods—we are about the same age—my memory hovers like a shade about the magic circle which Ulysses drew in Hades, but finds no Tiresias to lift the veil with which oblivion has covered the past. Shadowy as are these recollections, which—

. . . . be they what they may
Are yet the fountain light of all our day.
Are yet a master light of all our seeing."

They are doubly precious from their association with men who welcomed me into the Faculty, now, alas, a sadly reduced remnant ! "

* * * * * *

Books and Men, Boston Medical Library, 1901.

Within a quarter of a century our libraries will have certain alcoves devoted to the historical consideration of the great diseases, which will give to the student that mental perspective which is so valuable an equipment in life. The past is a good nurse, as Lowell remarks, particularly for the weanlings of the fold—

" 'Tis man's worst deed
To let the things that have been, run to waste
And in the unmeaning present sink the Past."

Rugby

PROSPECTS FOR SEASON 1943–44.

THE Rugby Football Club has reached an historic stage in its career, and season 1943–44 marks the centenary of the club's foundation. Arrangements have accordingly been made to make the season as memorable as war-time conditions will allow. This is the first centenary of any Rugby football club in existence with the exception of Rugby School, where the game started, and a further chapter will be written when Guy's meet Past and Present Rugbeians in Rugby Close.

The centenary match in London is against London Rugby Union, and a meal will be provided in the pavilion at Honor Oak Park after the game.

We shall miss the sterling play of Dr. T. L. T. Lewis at full-back and Dr. A. G. Albers from the pack, both of whom have rendered excellent service, not only to the rugger club, but as boxers and housemen. They will be returning to South Africa.

D. M. Strathie will probably return to his old position at stand-off in the absence of W. H. Lillywhite, and if P. L. Brangwin finds himself recovered from last season's illness he may solve the problem at full-back. The Macrae-Gibson brothers are available, and, together with R. D. Willcock, the back division, although uncertain, may be stronger than at first anticipated.

Of the forwards, A. B. Lee, the new captain, will have most of the old pack. He should not worry unduly because there are several good players from Tunbridge Wells yearning for a chance.

The fixture-list is strong and attractive, as indeed it should be, for a centenary season, and it remains to be seen how the team tackles it. One thing is certain, the rugger men of Guy's are determined to make this centenary season one of the brightest in the club's history, and they start with the good wishes from clubs and players all over the country.

FIXTURES 1943–44.

Date.	*Ground*	*Opponents*
1943.		
Sept. 25	H.O.P.	Past and Present.
Oct. 2	H.O.P.	Middlesex Hospital.
,, 9	Ch slehurst	St. Bart's Hospital.
,, 16	H.O.P.	Coventry.
,, 23	H.O.P.	St. Thomas's Hospital.
,, 30	Oxford	Oxford University.
Nov. 6	H.O.P.	Wasps.
,, 13	Teddington	St. Mary's Hospital.
,, 20	H.O.P.	Royal Australian Air Force.
,, 27	H.O.P.	London R.U. (Centenary Match).
Dec. 4	Rugby	Past and Present Rugbeians.
,, 11	Old Deer Park	Rosslyn Park.
,, 18	H.O.P.	R.N.E. College, Devonport.

1944.			
Jan.	1	Chislehurst	Middlesex Hospital.
,,	8	Bedford	Bedford.
,,	15	H.O.P.	United Hospitals.
,,	22	Cambridge	Cambridge University.
	29	Hale End	London Hospital.
Feb.	5	H.O.P.	R.N., Portsmouth.
,,	12	H.O.P.	R.N.Z.A.F.
,,	19	H.O.P.	O.C.T.U., Sandhurst.
,,	26	H.O.P.	A.N.Z.A.C.
Mar.	4	H.O.P.	St. Mary's Hospital.
,,	11	H.O.P.	Bedford.
,,	18	H.O.P.	Combined Oxford and Cambridge.
,,	25	H.O.P.	Rosslyn Park.
Apr.	1	Sudbury	Wasps.
,,	8	*Easter Saturday.*	
,,	15	Inter-Hospital Sevens.	

H.O.P.—Home Ground at Honor Oak Park.

Hospital Information, etc.

Notices

The Medical School have received an invitation from the U.S. Government Office of War Information for the use of the American Library at the American Embassy in Grosvenor Square. The library is concerned mainly with all phases of American life and current literature; it is open on all weekdays 9 a.m.–7 p.m. and should provide useful information for those interested in the views and outlook of our New World allies.

EXAMINATION FOR THE GOLDING-BIRD MEDAL AND PRIZE IN OBSTETRICS AND GYNÆCOLOGY.

August, 1943.

The following Awards have been made:

W. Homer Smith .. Medal and Scholarship
J. Lorber .. .. Certificate.

EXAMINATION FOR THE GOLDING-BIRD MEDAL AND PRIZE IN BACTERIOLOGY.

August, 1943.

The following awards have been made:—

R. E. Irvine .. Medal and Scholarship.
A. St. J. Dixon .. Certificate.

EXAMINATION FOR THE LEONARD LUBBOCK PRIZE IN CLINICAL PATHOLOGY.

August, 1943

The following awards have been made:—

J. O. Laws, A. St. J. Dixon } equal—Prize divided.
E. A. Wright .. Certificate.

Pass List

UNIVERSITY OF LONDON.
SECOND EXAMINATION FOR MEDICAL DEGREES.
July, 1943.

S. Adler	J. M. Hall
G. D. Banyard	H. Herbert
G. F. Barnes	R. W. Hughes
A. G. Bearn	J. G. P. Hutchison
K. W. Bolt	C. L. Joiner
D. F. V. Brunsdon	C. D. Korn
W. M. Dixon	J. B. Moore
A. E. Doyle	T. N. Reynolds
P. J. Dwyer	P. Sattin
E. J. F. Filose	M. E. N. Smith
J. J. Fingard	J. S. G. P. Stableford
T. R. L. Finnegan	G. F. Vaughan
R. V. H. Goulder	M. D. Warren
J. K. G. Grieves	J. T. Woodall

UNIVERSITY OF LONDON.
FIRST EXAMINATION FOR MEDICAL DEGREES.
(Internal Students.)
July, 1943.

K. T. Anderson	S. A. Jolliffe
K. A. Baker	E. Killey
A. S. Bligh	J. E. H. Lahaise
J. T. Cecil	W. G. Lewis
D. G. Chalmers	R. A. J. Mayhew
A. R. Davis	R. A. Miller
J. R. Deacon	H. H. B. Perkins
D. C. Deuchar	D. F. Potter
C. J. Earl	H. H. Richards
E. W. Graham	H. R. C. Riches
J. R. Greaves	P. Ronchetti
A. K. Hancock	P. A. Shave
A. J. Heber	E. J. Stafford
A. W. Hilliam	J. L. Warren
N. R. Howells	F. R. H. Wrigley

CONJOINT BOARD.
PRE-MEDICAL EXAMINATION.
September, 1943.

Chemistry.

R. E. Feaver	A. S. Goldie

Physics.

H. E. G. Dyer	D. W. Leatherbarrow
R. E. Feaver	C. B. Palmer
R. L. Leader	K. D. Watts

Biology

R. L. Leader	D. W. Leatherbarrow

Marriages

FULLER-JENKINS.—On August 28th at St. James's Church, Forest Hill, G. C. Fuller, Surg.-Lt. (D), R.N.V.R., to Joan O. Jenkins.

HOGG—NEWMAN.—On September 16th, 1943, at St. Mary's North Church, Herts, John Kenneth Hogg to Mary T. C. Newman.

Deaths

RUSSELL.—On February 14th, 1942, presumed killed in action at sea, Winifred Russell, Q.A.I.M.N.S. (*Guy's*, 1914).

SCOTT.—On September 7th, 1943, at The Hayes, Inchbrook, near Stroud, Arnold Scott, M.D.(Lond.), late of Bocking.

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

PERHAPS an apology would seem necessary to the majority of readers for the contents of this issue of the *Gazette*. It is primarily intended for the benefit of a minority—those now entering Guy's, whether nurse or student, medical or dental, and for those who start their clinical period in a fortnight's time. We feel that the various articles are of real value to these particular groups and are none the worse for the repetition which is entailed. Our regret is that the articles are not commonly brought to the notice of those who happen to start their training at other times during the year. We venture to hope that other readers will glance through them so that, in the light of their own experience, they may appreciate the excellence of the advice given in them. Thus we feel fully justified and able to flout any criticism suggesting an editorial holiday, though, if the truth be known, it is no such thing.

The story of the *Gazette* has been told recently in these columns, but its policy has never been given great consideration. Theoretically it is ruled by the *Gazette* Committee on which are representatives from all interested branches of hospital life, but in practice, within limits, it is left to the Editors to procure, accept and publish articles which are thought to be suitable. So we are left 'twixt a varied public (awful !) on the one hand, with a balance-sheet and, most exacting of all, a paper controller on the other. The last has to be satisfied first—the *Gazette* must be a periodical for the education of students, twenty pages a fortnight (8½ by 5½ in.) and two extra occasionally if you behave. Formerly the *Gazette* would fill anything upwards of thirty-six full-sized pages, a very considerable cut, yet to attempt to compile a *Gazette* of that size at the present from the contributions proffered would almost certainly lead to the timely rescue of the hapless Editor from the Pool of London by the River Police. We realise that everyone is working to capacity now and that they are loth to promise articles—not because they are so completely pressed, but because the vagaries of life at the moment make any like promise an uncertainty.

This is where our task begins and, incidentally, where you, the reader, come in. Surely you have some preferences ? Great is the editorial rejoicing on receiving a letter if only to say that if we persist in publishing such-and-such the writer sees no further point in continuing his subscription ! The quiet acceptance of every opinion expressed by contributors, no doubt out of deference to their position in the Hospital, is to be deplored. Certainly in an institution such as Guy's the opinion of the senior man in each department will tend to be the accepted view more than in the profession as a whole ; but that it should be beyond criticism is impossible, and we suggest that it would be to the stimulation of active thought in the Hospital were these pages used to thrash out the conflicting views which must exist on so many points. Finally, let us venture to suggest that space could well be devoted to the reports of interesting cases or series of cases which have been seen in the wards, written up by the ward-clerk or dresser with the help and advice of the registrar. While contributing to the interest of the *Gazette* they would acquire valuable experience towards writing for the national medical journals later.

WINDOWS have been stripped of their strengthening bands, wards are being opened on ever higher storeys—even Eros is slowly appearing from under his shroud of sandbags, yet old Thomas Guy still remains entombed. May we suggest his release, if only for the benefit of our American visitors ?

IN pre-war days a list of new entrants to the Medical and Dental Schools was published in this special number. After a lapse, the custom was revived twelve months ago and it was intended to continue this year ; unfortunately School Certificate results have been delayed and the lists are not yet settled. We hope to include them in our next issue.

Obituary

SIR FRANCIS FREMANTLE, O.B.E., D.M., M.Ch., F.R.C.P., F.R.C.S., M.P.

BY the death of Sir Francis Fremantle the country loses the services of a man who devoted the greater part of his life to the promotion of the national health. He was born in 1872, the great-grandson of Francis Fremantle, one of Nelson's captains, who commanded *Neptune*, the second ship behind *Victory* at Trafalgar. His grandfather was at one time Secretary of War and was raised to the peerage as the first Lord Cottesloe. His father, the Very Rev. and Hon. W. H. Fremantle, became Dean of Ripon and gained some notoriety in the early days of the century for his bold attempt to provide a scientific explanation of the Immaculate Conception.

When I came to Guy's as a complete stranger in October, 1901, the first person to speak to me was Frank Fremantle, and for over forty years he remained one of my best friends. He had just returned from South Africa, where he had been serving in the Boer War as a civil-surgeon, and he was acting as Assistant Secretary to the War Office Commission for the Reorganisation of the Army Medical Service. He was living in the College in a room opposite mine, working for the final Fellowship examination. He had chosen medicine for his career whilst still a King's Scholar at Eton, showing in this way some independence of thought, for the number of Etonian doctors is remarkably small. I can think of only three at Guy's in forty years. After taking honours in physiology at Oxford, he did the usual clinical appointments, including house-physician to Dr. Newton Pitt. For two years he was editor of the *Gazette*. When I first knew him he had recently learnt that he would some day inherit Bedwell Park, near Hatfield, from a maternal aunt and that he would then be no longer dependent on his professional earnings. He therefore drew up a kind of twenty-year plan to prepare himself for the day of his inheritance, when he hoped to enter Parliament for the constituency in which the estate was situated. He must have been the first doctor who deliberately trained himself for a parliamentary career by learning all he could about every branch of the profession. It was with this idea that he accumulated an almost unique collection of degrees and diplomas. He was one of the few men to be both a D.M. and M.Ch. Oxon., as well as M.A.; he was a Fellow of both of the Royal Colleges, and he held the D.P.H.

He was an excellent talker and was a delightful companion both in London and at his charming country home. He was a devoted son of Guy's and was very happy when last year his long association with the Hospital was made still closer by his election as a Governor. He greatly enjoyed a visit he paid a few months ago to address an unofficial gathering of students on post-war problems, and the excellent discussion which followed showed how greatly his talk had been appreciated. He was always ready to use his influence to help members of the medical profession in any difficulties they might have with Government Departments, and he regarded himself as much a representative of our profession as of his St. Albans constituents.

In order to gain a general insight into public health problems he took the appointment of M.O.H. for Hertfordshire in 1902. He obtained leave of absence to act as plague medical-officer in the Punjab in 1903, to be special correspondent of the *Lancet* in the Russo-Japanese War in 1904, and to tour the Empire in 1911. He described

his varied experiences in *A Doctor in Khaki* (1901) and *Health and Empire* (1911). He served as D.A.D.M.S. in Gallipoli, Egypt and Mesopotamia in the 1914-18 war, and was awarded the O.B.E. and twice mentioned in despatches.

From 1919 until his death on August 26th he was Conservative Member of Parliament for St. Albans. He soon became recognised as the leading spokesman of the medical profession in the House of Commons and was accepted as an authority in all matters relating to public health. In an appreciation in the *Times* Sir Henry Morris-Jones, another medical M.P., describes the all-parties Parliamentary Medical Committee, of which Fremantle was Chairman from 1923, as the Committee which was nearest his heart. "To it he gave without stint. His loss on the eve of proposals in the direction of a comprehensive national health service will be severely felt. Although his experience and training qualified him more particularly in the realms of public health and housing, he had great admiration for, and sympathy with, the general medical practitioner—that often much harassed individual who must be the pivot of any scheme of health service. Fremantle was one of the most industrious members of Parliament I have met. There would be a very compelling reason for his absence from the House, even for an hour, such as an important constituency or other public engagement. When parliament was sitting he could always be found in one of three places—in his seat behind the Ministerial bench ; in a committee room upstairs ; or in the library, coping with a pile of papers and letters—always working. He truly gave his life for his country."

Fremantle always tried to put before the House the strictly medical and scientific aspects of the subject under discussion. Though not brilliant, he was extremely painstaking, and his opinions invariably received the attention they deserved. Fremantle was a member of the Industrial Health Research Board, the Departmental Commission on the Midwives Act, the Central Housing Advisory Committee of the Ministry of Health and the Inter-departmental Committee on Nursing. In 1920 he was President of the Incorporated Society of Medical Officers of Health, and in 1928 President of the Section of Epidemiology and State Medicine of the Royal Society of Medicine.

He was courteous and friendly to all, and his popularity in the House was only increased by the occasional spoonerisms he committed. The last and perhaps choicest was during the recent debate on the decline of the population, when he demanded a bill "to control the sale of Conservatives." On this occasion he spoke with great earnestness on the causes and probable effects on the future of the nation of the declining birth-rate. His books brought his views on health problems before a wider public. In addition to those already mentioned they included works on *The Housing of the Nation*, in which he pointed out the shortcomings of housing as they appeared to a M.O.H. in 1927, and on *The Health of the Nation* (1928). It would be impossible to find room to mention all of the associations and committees of which he was an active and useful member. Among the more important were Lord Trevethin's Committee on Venereal Diseases, the British Empire Cancer Campaign, the National Institute for the Deaf, the British Empire Leprosy Relief Association, the British Social Hygiene Council and the Central Association for Mental Welfare.

Fremantle was a member of the Central Medical War-Committee and Chairman of its Aliens' Sub-Committee. Many refugee doctors owe him a great debt of gratitude for his personal efforts on their behalf.

He took an important part in the foundation of the London School of Hygiene and became one of its first Court of Governors. From 1920 to 1923 he was a member of the L.C.C. and was chairman of its Housing Committee. He was an enthusiastic supporter of the garden city movement, and was chairman of council of the Garden Cities and Town Planning Association and director of the Welwyn Garden City in his own county of Hertford.

He was liked by members of all parties in the House and was equally popular with all classes in his constituency, where he was Deputy Lieutenant for the County and Justice of the Peace. He was deeply religious and was a member of the St. Albans Diocesan Conference and the Church Assembly. The last time I saw him was a few weeks ago when he visited Oxford to attend the Modern Churchmen's Conference and gave an address on "The Layman's Rights and Duties."

Fremantle was knighted in 1932. He married Dorothy, the only daughter of the late Mr. H. J. Chinnery, of Frigford Manor, Bicester, in 1905, and had one son, Lieut. Col. David Fremantle.

A. F. H.

To those Entering the Clinical Period

By Dr. A. H. DOUTHWAITE.

YOU who are entering the Medical Wards do so under much more favourable conditions than those which existed when I last wrote this welcome. On the other hand, the resulting enormous increase in the work of the Hospital departments should more than ever put you on your mettle to work to your limit to help Guy's in its great task, as well as to acquire knowledge for your own benefit.

The type of student who complacently allows routine examinations to be carried out in the laboratories rather than perform them himself is not wanted at Guy's and will be made to realise it. Drifting into Out-patients at 10.30 a.m. and unobtrusively sidling out an hour later is a poor preparation for the day when he finds himself in sole charge of men's health and lives. In short, work as you have never worked before. Imagine always that you have sole responsibility for your cases. Picture to yourselves what ought to be done, and decide which of these investigations you are capable of doing unaided. Then, with the permission of your house-officer, do them. You will learn more in three months on these lines than you would in five years of formal lectures.

As to the planning of your studies, last-minute cramming for final examinations is of no use. The subject is too vast for any than gradual absorption, so it is well to follow some plan from the outset. The Preliminary Clinical Period prepares you thoroughly for the routine examination of patients, and thus prevents waste of time when you enter the wards. Beds and their human contents are allotted to you, and *therewith your share of responsibility.* The taking of the medical history is the most important step towards arriving at a diagnosis. This is primarily your job, and its value cannot be over-emphasized, though too often forgotten in a desire to search for physical signs of disease. The ability to sift the relevant facts from matter which obscures can only come with experience. In the meantime, bear in mind the value of facts, as opposed to patients' interpretation of them, and of their presentation in a legible, and, where possible, schematic, form. When writing a report, do so with the thought that on its accuracy may depend the outcome of valuable research undertaken years later. Whenever possible, examine your patient before he is seen by the registrar, and commit yourself to a diagnosis. Progress of the disease, its outcome, treatment given, opinons expressed on diagnosis, should all be entered to make the records of lasting value. Write down your findings and conclusions. It is the only way to avoid that type of mental dishonesty which leads to brilliant differential diagnoses any one of which can be claimed as a personal success at a later date ! This dangerous habit once acquired is difficult to discard. It meets with but scant respect, however, from the relatives of the sick. Mistakes have a high educative value. They snatch one with a jerk from the danger of self-complacency.

Probably the best plan of study is to concentrate for the first three months on pathology. This entails, of course, frequent visits to the post-mortem room. Given this grounding, symptoms and signs become the natural expression of the disease and their memorising is unnecessary. The most valuable time of the day for the acquirement of practical knowledge is that which follows the afternoon round. It is then that the house physician performs lumbar punctures, collects blood, taps chests and so forth. These procedures should be watched and from time to time you will be given the opportunity of carrying them out yourself. It is now, also, that special signs referred to in the teaching round can be re-examined and thus fixed in the memory. It should be made a point of pride that within a fortnight you should be able to inspect the optic discs of any patient you may choose. Once the knack has been acquired, and it usually comes quite suddenly after several days of disappointment, it will never be lost. It takes many months to be certain of the normal as opposed to the diseased disc, yet recognition of early change may be of the utmost importance in determining a diagnosis and possible even in saving a life.

The patients in your beds will confide in you possibly more than in the house officers or staff. To them you are their doctor and from you they will try to get confirmation of their fears in respect of illness, or of suspicions in relation to earlier treatment. An immense amount of mischief is caused by the making of unguarded remarks

which can be misconstrued. Their avoidance is doubly difficult in a teaching hospital, where a discussion on the problem is too often carried out within earshot of the patients. We all err unwittingly in this respect, and the importance of discretion needs reiterating. The fact that a patient can inspect his own report is deplorable and should be remedied.

Attend Out-patients' when you can. This is the only hospital activity which remotely approaches the conditions which obtain in general practice. The frequent absence of physical signs may be tedious, but precisely for this reason is the experience invaluable in forcing you to rely more and more upon history-making. It is an antidote to the poison of mechanised medicine, whose virulence increases with every new instrumental aid to diagnosis.

Insure your life and health, and join a society for protection against legal action as soon as you are qualified.

In moments of despondency remember that Medicine is the only profession which never provides two days which are alike, and in which boredom is a rarity.

The Clinical Period in War-time

OWING to the small number of beds available for patients at Guy's, it is necessary for a number of the students' appointments to be held in the Emergency Medical Service Hospitals in Sector X.

It may be useful for those now entering the wards to outline the distribution of these appointments.

Owing to the fact that students are now permitted to sit for the first part of their final examination after twenty-four months in the wards and to qualify in thirty months, it has been necessary to rearrange the curriculum and combine some of the appointments.

The first three-month appointment undertaken on entering the wards is now a combination of the old pre-clinical period and surgical ward clerk; this is done at Guy's, as is also the next three-month appointment of medical ward clerk. During this six months the student (first three months) attends courses in elementary pathology and bacteriology and has an opportunity of joining in the various other activities at the mother hospital. The next two appointments, each of three months—*i.e.*, junior dresser and medical ward clerk (second three months) are held at the County Hospital, Farnborough, with some extra teaching at the E.M.S. hospital at Orpington.

The student now returns to Guy's for the three months' "free period," when his time is filled up by appointments in the eyes, skin and V.D. Departments and instruction in fevers, vaccinations and the administration of anæsthetics, etc.

The study of midwifery, gynæcology and children's diseases occupy the student for the next six months, which is spent either at the County Hospital, Farnborough, or the County Hospital, Pembury. A fortnight of this period is spent in residence at Guy's, whilst doing a term of duty in the labour ward.

The student now returns to Guy's again, where he does the compulsory appointments of E.N.T. dresser and senior surgical dresser. During this time he has an opportunity of attending general out-patient departments and gaining practical experience in the wards and the Surgery.

Appointments in the special departments, several of which can be held conjointly are now available for students who have completed the compulsory curriculum. The Out-patient departments of all these specialties are at Guy's, but the In-patient work is mostly done in the Sector Hospitals, and the student is advised to visit these as often as possible.

Every student should, at the beginning of the clinical period, visit the medical school offices at Guy's and review broadly his plans for filling in courses of compulsory lectures at Guy's and elsewhere with his proposed appointments in the Sector hospitals.

The Dental Curriculum

By F. BOCQUET BULL, Sub-Dean of the Dental School.

FOR over a period of half-a-century a yearly welcome has been extended to the new dental students at Guy's Hospital, and once again the Hospital and School extends that welcome to you. More briefly this year, owing to war-time restrictions, but none the less just as heartily. Where words have to be limited it is unnecessary for me to bother you here with advice as to your actual programme of studies, except to say that at any time that you are in difficulty in this and other respects do not hesitate to seek advice from the Dean or Sub-Dean or other officials at the Medical School Office.

The motto of the Hospital is *Dare Quam Accipere,* and the Hospital and School gives freely and willingly of the very best to all students and, in return, expects to receive the very best from its students.

It is true to say that in the past this reciprocity has rarely failed ; and it is partly for this reason that the name of Guy's and all that is associated with it stands in such high repute the world over.

At the present time you are commencing the study of a profession in vastly different circumstances from times of peace, and it is only because of the importance of Dentistry to the well-being of the Forces and the civilian population that you are enabled to do so. Your acceptance by the School as a student has placed you in a reserved position, but that reservation carries with it certain conditions, two of which have been explicitly stated—viz., that you make satisfactory progress, and that you assist in some way or other in the civil defence of the country. Of this you are probably aware, but I would point out to you that there is an unwritten condition which depends upon you, and you only, to carry out. You are reserved in order that you may place yourselves in a position at the earliest possible moment to help your country in your own particular sphere—viz., as Dental Surgeons. To do this means diligent study without slacking and a full and proper realisation of the fact that by working hard you are only, after all, carrying out conscientiously your side of a contract. The fulfilment of this obligation depends entirely upon you and the spirit in which you carry it out. By conscientious work in honouring the trust imposed upon you, you will bring credit to yourself and your School ; by abuse of this trust, the reverse.

By this I do not mean all work and no play, for this will only lead to staleness ; but when you work, work hard, and when you play, play in the same manner. Keep a proper balance between your work and recreation, at the same time not forgetting that, at the present time, work is at a premium ; leisure at a discount. Work and play in this spirit and your years at Guy's will prove to be some of the happiest of your life.

To those Entering the Nursing Profession

THERE is no shortage of candidates for Nursing training at Guy's and, during the last eighteen months, the Preliminary Training Schools at Guy's and Tunbridge Wells have been sending into the wards the full quota of student nurses every two months. You may all now look forward to spending a longer time at Guy's during your training—and thus we hope you will absorb some of the spirit of nursing which has been the inspiration of Guy's nurses for several generations and which is inevitably linked up with the parent hospital and its strong traditions. Our nurses, however, are still in great demand in the base hospitals and at the Wildernesse. Wherever you may be working, you are judged by your patients as a Guy's nurse. Many of them from the Borough have definite expectations from past experience and you must not disappoint them. You must create in your wards that spirit of homeliness, friendliness and help, which is irradiated from yourself as an individual quite apart from any nursing knowledge and skill which you may acquire during your training. There is much of the latter to be learnt before your name can be entered on the State Register of Nurses, but it is all of little value unless you love your work and are enthusiastic for your patients' recovery and happiness whilst under your care.

The future is full of hope for the trained nurse—abundant work, enlarged scope for nursing services and reasonable rewards for work done. Good luck, and may you yourselves be satisfied and happy in your choice of career ! H. W. G.

Guy's Hospital Clubs' Union

OWING to the limitation of space it will not be possible in this special number of the *Gazette* to give a full survey of the activities of the Clubs' Union. Nevertheless the changes brought about by war conditions demand that the present status of the Union be fully understood.

For upwards of fifty years the affairs of the various clubs and societies have been under the partial control of the Clubs' Union Council, a body consisting of staff and students in whom is vested the power to allocate material or financial aid to one or other club as is deemed fit. The amalgamation has the great advantage in that it simplifies the collection of subscriptions which before that time had been a complex, if not a hopeless, business. Nowadays one subscription only is levied and this carries with it membership of any or all the constituent institutions (as are listed below), a free copy of the *Guy's Hospital Gazette* and the full use of any of the Clubs' Union premises, in particular the athletic ground at Honor Oak Park.

A second advantage is that the central control of the funds allows a fair distribution to be made to each club, whether the membership be large or small, and ensures continuity of purpose when it might otherwise be endangered by lack of support such as is always liable to occur when the more active members become qualified and leave the Hospital. As a result the years have seen a gradual growth in the number of its constituent bodies and the exploits of Guy's men in the field of sport are justly renowned.

It will be seen that membership enables the student to broaden his outlook both in the athletic and educational worlds. For those interested in sport exceptional facilities are available for increasing their proficiency, whether in a friendly game or an organised match. Fixtures have, of necessity, been curtailed since all unnecessary travel has been cut out and many opponents have had to close down for the duration of the War. None the less, the various secretaries should be congratulated in overcoming these difficulties, for, by arranging inter-hospital matches and games with representative teams of the three Services, an entertaining list of fixtures has been assured.

The Physical and Dental Societies provide opportunities for students to air their views on medical or dental matters. At these meetings cases from the wards are shown, controversial opinions expressed and from time to time papers are read on subjects of general interest. All members are strongly advised to support these societies both for the advancement of their knowledge and for the chance they offer of taking part in the discussions. The Debating Society gives similar opportunities ; there is practically no restriction on the topic discussed and, though its activities have been rather quiet of late, it is hoped that it will blossom forth this winter.

One of the most important bodies of the Clubs' Union is the Students' Club. Its purpose is to provide ample accommodation for students in their moments of leisure and newspapers, periodicals and journals in so far as funds will allow.

At Guy's the new Physics Laboratory has been converted into a reading room and necessary furniture provided. At Farnborough rooms have been set aside in Summerlands, and at Pembury a hut has been erected in the hospital grounds.

For the new students, most of whom will be living in the Tunbridge Wells area, the Clubs' Union has rented a large room in Kentish Mansions near the Pantiles, where comfortable chairs, periodicals and a table-tennis set are provided. The rooms are open from 9 a.m. until 10 p.m., and it is hoped that full use will be made of them this winter, particularly during the long evenings, when, doubtless, it will be possible to arrange for suitable refreshment.

It is not possible in this number to review the manifold activities of the various clubs during the past year, and the reader is referred to a similar copy of the *Gazette* published on October 18th, 1941. This may be obtained from the Wills Library at Guy's on application to the Librarian. Therein will be found details of the arrangements made by the various clubs as they affect the student in the particular area in which he finds himself. The majority hold good to-day and, at the request of the Editor of the *Gazette*, it is proposed only to give a list of secretaries who will be pleased to supply further details as regards grounds, changing accommodation, fixtures, etc., on being approached by interested members.

The new student, on obtaining membership of the Clubs' Union, is strongly recom-

mended to watch the notice-boards in the Colonnade at Guy's, in Summerlands, the students' hut at Pembury, and at Sherwood Park, Tunbridge Wells, where information regarding meetings and practice games will be posted.

It is unfortunate that the new student, who now spends his first years at Tunbridge Wells, will not immediately reap the benefit of having the excellent athletic field at Honor Oak Park close at hand. Before the War this was, naturally enough, the centre of attraction, whereas now he has to be content with the accommodation available at the various clubs in the Tonbridge and Tunbridge Wells districts. None the less the Clubs' Union has been fortunate in being able to rent admirable grounds in the near vicinity and, when time permits, it is hoped that as many as possible will make the journey to Honor Oak, where a Saturday afternoon watching Rugger, followed by tea in the pavilion, has all its former attractions.

For all the above advantages and many more not listed the annual subscription now stands at four guineas, payable in October of each year.

All students who wish to enter fully into the life of Guy's are earnestly advised to join.

Below is a list of secretaries now to hand. Apologies are made for any inadvertent omissions.

Rugby Football Club ..	A. BATTY-SHAW	Athletic Club	B. S. WILSON
Association Football Club	F. R. M. YOUNG	Hare and Hounds ..	G. F. VAUGHAN
Hockey Club	J. R. BURT	Swimming Club ..	B. H. PICKARD
Cricket Club	G. W. GARLAND	Boxing Club	(To be elected)
Lawn Tennis Club ..	K. Y. KHONG	Students' Club	S. H. WASS
Golfing Society	D. C. STEVENS	Dental Society	P. C. S. CAMPION
Squash Club	(To be elected)	Students' Union ..	B. D. GRANT
Sailing Club	S. A. MARSH	Physical Society ..	Local secretaries to be elected.
Rowing Club	M. D. CREMIN		

F. R. KILPATRICK,
Hon. Secretary, Clubs' Union.

Reviews

A Synopsis of Regional Anatomy. By Professor T. B. JOHNSTON, M.D. Published by J. & A. Churchill, Ltd. Fifth edition. *Price* 16*s*.

THIS is the fifth edition of a book which has gained for itself a well-deserved popularity among students. It is intended solely for revision purposes after dissection has been completed. The preface and foreword clearly describe the author's aims and give useful advice on revision. There are no illustrations except for a few neurological diagrams, for bones and dissected parts should be studied with the book. Anatomy is to be learnt in the dissecting room, not an armchair.

Emphasis is laid on facts of practical medical significance and unnecessary detail is largely avoided. Italics have been used most effectively to draw attention to points likely to be overlooked. There is a functional outlook throughout the book, seen particularly well in the accounts of the actions of muscles, where their use in everyday activities are described instead of a bald statement that they produce flexion, etc., at such and such a joint. In the central nervous system, too, structure and function are especially well correlated.

An exception to the description by regions is the separate section on osteology. But bones mostly extend into several regions and it is not practicable to describe them in parts. The author avoids boring the reader with accounts of the obvious features of bones; instead, he concentrates on their ossification and other information important in the diagnosis and treatment of their injuries.

Reminders of their development are given in the description of organs, but no systematic revision of embryology is attempted. This would require numerous illustrations and considerable text-space and would merely duplicate the accounts given in the standard text-books of anatomy. Criticisms are few and are mostly in matters of detail.

The root values of several important nerves are not given, in particular the femoral in the leg and musculocutaneous in the arm. A more important omission is the overlapping of the segmental distributions of the nerves of the trunk.

The brief mention of the fascial spaces of the hand could well be expanded, for a knowledge of them is essential for the correct treatment of septic hands. But such criticisms are trivial compared with the basic soundness of the book, both in facts and method of presentation. The reviewer is confident that students of to-day will find this fifth edition as valuable as the third was to him. G. F. S.

After-Care and Rehabilitation. By various Authors. Edited by Sir HUMPHREY ROLLESTON, Bt., G.C.V.O., K.C.B., M.D., F.R.C.P., and ALAN MONCRIEFF, M.D., F.R.C.P. Published by *The Practitioner*. *Price* 8*s*. 6*d*. *net*.

THIS is a very good book and in great part well and thoughtfully written. There are twelve chapters, four dealing with post-operation care and the rest with rehabilitation.

From the post-operative aspect the main omission is that shock is so much more easily treated by intravenous infusions during the operation than afterwards, when it has fully developed. There is a little variance about the exhibition of morphia, but the injunction in Chapter I is preferred.

The rehabilitation section is good; the function of rehabilitation is to restore the disabled to working capacity as speedily as possible. For that a team is needed, with the surgeon or physician as the leader. In Chapter IX the necessity for the disabled to exercise his muscles and develop power without realising the matter is stressed, and that idea is preferable to that of those who aim to educate particular muscles by particular exercises. Chapter V is the least well written and contains some loose statements. The doctor who waits for an empyema to point or who hopes that short wave will hasten the absorption of the cheese-like material inside one, knows very little about modern chest surgery. In Chapter XI the paragraph on manipulation is poor; the need for repeated small manipulations is not stressed, and the aim of the manipulator should be to do as little as possible. In that way the writer's difficulty about post-manipulation pain will be overcome.

This is a book which is very well worth reading by all who study medicine.

A. F. R.

Rose and Carless' Manual of Surgery. By CECIL P. G. WAKELEY, C.B., D.Sc., F.R.C.S. Published by Baillière, Tindall & Cox. Seventeenth Edition. Two volumes. Vol. I, and xx 840 pp.; Vol. II, 926 pp. With 30 plates and 1,100 illustrations. *Price* 35*s*.

THIS is the second edition to have been brought out during the War, and it includes new sections on burns, blast and compression syndrome. Surgeon Rear-Admiral Wakeley has been prominent in the study of these particular problems, as is demonstrated by the excellence of these sections. It seems a shame that the rest of the chapter on war surgery should have been included, if it had to be treated in such a sketchy manner.

Although conforming to war economy standards the book is very well printed on a good quality paper. A number of excellent new illustrations bring these volumes well above the general average of British text-books in this respect.

These volumes, and others of similar type, are produced as books of reference for students and practitioners. It is often necessary for students to read whole sections upon various conditions with which they have but slight chance of coming into contact during their clinical period. Each section is then so similar in its presentation, thought and even phraseology that the slightly dull text becomes duller. It seems time for the production of an authoratitive English text-book in which a large number of acknowledged experts in different fields of surgery should collaborate. E. R. D.

Design and Purpose. By FREDERIC WOOD JONES, D.Sc., F.R.S., F.R.C.S., Professor of Anatomy in the University of Manchester. London: Kegan Paul, Trench, Trubner & Co., Ltd. 1942. Pp. 84. *Price* 5*s*.

"IN looking back, it seems incomprehensible how the publication of Charles Darwin's thesis could have created such an upheaval of thought, should have led to so profound a readjustment of values and so great a forgetting of what had gone

before " (42). One of the results of this upheaval was that men began to wonder whether the Universe has any guidance, whether there is any purpose in all they see and hear. Some did not think there was enough evidence to tell one way or another, and for this mental standpoint Huxley coined the word " Agnosticism." Others definitely decided that there was none, and Atheism, open or latent, became more usual. But the mind of man, like the minds of men, must be always moving, and there comes a time when the agnostic frame of mind degenerates into a doubting folly. And so the age of agnosticism is passing and men must decide whether there be a God or not. And here is Professor Wood Jones to put before us the modern evidence that there is, that behind all we see there is design and purpose, and to conclude with an exposition of the Perfect Way. The occasion is timely.

" It would probably be true to say that there are to-day three classes of people who hold the stage upon which is being enacted what is probably the most thrilling drama, possibly the most horrific tragedy, in which humanity has ever taken part. One of these classes may be dismissed as supers, as the chorus, as the crowd, the villagers or what you will. In this group are the great unthinking mass of the people who applaud, condemn, approve or dissent in unison and without thought for the future or any real perspective based on a knowledge from a study of the past. The great distinction of this class is that it is refraining from thinking beyond the requirements of the daily round.

" Of the two classes that are aware of the crisis that is inevitably to come and are therefore thinking beyond the demands imposed upon them by the immediate present, both are contemplating the future with anxiety : on the one hand with fear ever in the background, on the other with hope which is, nevertheless, tempered with deep apprehension. . . . There are those who cherish the hope that a continuance of the order that has culminated in the crisis may, when the crisis is passed, rise once again to greater power upon the ruins created in the passage. . . . But there are others, perhaps better instructed in historical outlook, more alert to the possibilities of the future, who see that change is certain to come, that indeed there is a world crisis and this crisis must be faced . . . by a realisation that change is inevitable and cannot long be delayed " (19–21). It is for the third of these groups that Professor Wood Jones writes.

" There have been several distinct phases of thought in regard to the meaning of the relation of living function to living structure and of the relation of both of these to a wider scheme of things " (24). Primitive man had, and has, a sense of wholeness with Nature. He " regards himself and all his attributes and characteristics as a part of the general scheme of environment. He accepts his form, his functions, his emotions and even his thought processes as being shared in common with those objects that surround him " (24). Then came the advent of civilisation " in which, by urban residence, man became divorced from his natural environment and lived apart from the rest of Nature " (25). Doctrines arose in China and India and in Greece which made up " the so-called ' classical ' period with its characteristic outlook upon Nature " (26). " The distinction of man from the rest of Nature's products was assumed, although many philosophers were prepared at times to disregard it and to accept man as a very ordinary part of the scheme of nature " (30).

And then at the eastern end of the Mediterranean there arose the three monotheistic religions, " or, rather, the teachers of a common monotheistic creed arose in succession " (31), which produced two definite trends of thought, " a belief that man was directly created by God : and that he was created in God's image " (32). These ideas separated man from the rest of Nature ; he " was no ordinary part of the environment and was often notoriously in disharmony with it " (33). Perhaps this is the reason for the upheaval of thought that has puzzled Professor Wood Jones so much. It was a wrench to relise that the pious persons who had been preaching for years that all men are his brothers were biologically right, and that our first cousins are the gorilla and, more gently, the chimpanzee. And so he leads us on to a conception for the future based on the extension of the doctrine of evolution from the living to the non-living world, and the link between the two as represented by the work now being done upon the viruses. He ends upon the note : " God's in his heaven "—but very definitely all is *not* right with the world.

T. B. L.

Diseases of the Nervous System. By F. M. R. WALSHE. Published by E. and S. Livingstone. Third Edition. *Price* 15*s. net.*

MUCH praise has been given to earlier editions of this book, and its already widespread use make it unnecessary to enlarge on all its good points. Its general simplicity, coupled with its accuracy, make it an ideal book for students, and a useful reference book for all but the most obscure problems.

Of the alterations in the present edition, it is pleasing to note the new views on the ætiology of acute poliomyelitis. These have undergone such a radical alteration in the last few years and there is such excellent evidence for the modern ideas, that their incorporation seems only reasonable. Such reasons, however, are not always to be found in the authors of text-books for students, and deserves notice when it occurs. Other introductions are: descriptions of ocular movements and their place in diagnosis; the awkwardly, if appropriately, named pituitary-hypothalamic complex; infantile hemiplegia; and sinus thrombosis. All fall into place in the acknowledgedly restricted scope of the book and should add to its usefulness. J. O. L.

The Ear, Nose and Throat in the Services. By R. SCOTT STEVENSON, M.D., F.R.C.S.(Ed.) Major R.A.M.C. Oxford University Press. London; Humphrey Mitford, 1943. Pp. 116. *Price* 5*s. net.*

THIS is a good little book. There are fewer things in it with which one may be in complete disagreement and correspondingly more that are debateable, for in clinical medicine there are no such things as the generally accepted facts. When describing bleeding from the nose the author does not seem to have heard the name of Wilfred Trotter. In dealing with the tonsil problem he does not seem to know the meaning of the word "libel"; to hold an opinion is not libellous, to make a misstatement is, as when he says the guillotine operation "always" spatters blood on the surgeons, nurses and students. He should come and see an unqualified H.S. give open ether at Guy's. It is a pity that so useful a method of anæsthesia should be given so opprobrious a name as "the rag-and-bottle method" in a work that pretends to be a serious contribution to medical literature. Fig. 14 is excellent by showing into how small a space—not area—the sinuses open under the middle turbinal. Fig. 12, on laryngotomy, would be good if it depicted what he describes. "The larynx is fixed between the thumb and the middle finger." It shows the forefinger doing this. Fig. 8 may be of use to anyone that will not believe the statement that the largest size of aural speculum makes a good nasal one. The rest are as useful as figures in books usually are. I can recommend every M.O. who has room for it in his kit to purchase it with the pay he saves when doing his first course and any student who thinks he must buy a book on this subject. He will thus save his parents or guardians unnecessary expenditure. T. B. L.

A Medical Bibliography. A check-list of texts, illustrating the history of the medical sciences originally compiled by the late FIELDING H. GARRISON, M.D., and now revised, with additions and annotations, by LESLIE T. MORTON, Librarian, St. Thomas' Hospital Medical School. London: Grafton & Co. Pp. 412. *Price* £2 10*s. net.*

IT is not clear how much of this is Garrison and how much Morton or whether it is a new edition of an old work or a new work based upon a previous one. Nor does it matter, for it is a useful one suitable for any medical library (public, private or personal), and for a good many that are not medical. It is not a work in which the young enthusiast will be able, without hard striving, to compile a bibliography of the work in hand. Nor is it merely a book for enthusiasts in the history of medicine. It is for those who, looking to the future and new knowledge, believe that there is much to learn from the past. It is best described in the words of a great Guy's man, still remembered by many, with which Mr. Morton opens his introduction. "Every discovery, however important and apparently epoch-making, is but the natural and inevitable outcome of a vast mass of work, involving many failures by a host of different observers." Those taught by Starling, and those of us brought up in the tradition he left, will realise how true this was in reference to his own work. The book is well printed, neatly bound in a style that looks as though it will stand the repeated removal from the shelves that all books of reference are subjected to. Its price is one that must be faced by those that need it. T. B. L.

Pathological Histology. By ROBERTSON F. OGILVIE. Published by E. & S. Livingstone. Second Edition. *Price* 32*s.* 6*d. net.*

THIS book is designed to supplement the ordinary text-books of pathology and to assist the student with his practical work. In both these aims it can hardly fail to give satisfaction, as its illustrations, all in colour, are real representations of what one sees under a microscope reproduced with an accuracy which leaves little to desire. The text is kept short and consists of a description of the general, macroscopic and microscopic appearances of each lesion with, when required, a few remarks on the differentiation of conditions which may be confused with it.

Some features are worthy of mention. The series of seven illustrations of pericarditis, three in increasing magnifications of the acute stage, three similarly of the organising stage and one of the fully organised stage will, in association with suitable slides, convey to the student, the whole essentials of inflammation and repair. Tuberculosis and syphilis are always a source of confusion to the beginner, and the sections in this book illustrate the similarities and differences in a way which should give even a novice the best chance to tell them apart. While most of the sections are stained with the routine hæmatoxylin and eosin, where some advantage is to be gained the author has not hesitated to include some stained by less common methods—*e.g.*, Haidenheim's Azom method. The greater differentiation gained by this means is undoubtedly worth while and a wider use in class practice of demonstration sections stained by such methods, in parallel with the ordinary ones, would, perhaps, make for clarity in the early stages. Failing that, this book will help to fill the gap and is warmly recommended to everyone.

J. O. L.

Correspondence

POST-WAR INSTRUCTION.

To the Editor of the GAZETTE.

SIR,—The fact that those who have qualified during the War and are now serving as medical officers in the Services are inevitably forgetting much of the little they ever learned is, I think, generally appreciated. Your correspondent, "Guy Minimus," in your last issue, asks, "Are any steps being taken to re-instruct us . . .?" I suppose this is a purely rhetorical question, for no one that I know of has heard of any concrete plans being made, although tentative suggestions have appeared here and there.

It may be said that the best way in which to pick up the threads again will be to take house appointments. This is quite true and is, I suppose, what most of us will try to do. But two questions arise out of this :—

1. Will there be enough house appointments of the right kind to go round ?
2. Will the man who has married during the War feel inclined to try to keep a family on what is, at the moment, house-man's pay ?

I personally believe that the answer to both these questions is No; therefore I agree with "Guy Minimus" in suggesting that we should be given a period, say six months, of re-instruction (preferably at our own teaching hospital) before demobilisation. This would also give those who qualified Conjoint, but wish to take their M.B., more time for study.

It would be a pity at this time, when there is much talk of improving the nation's health services, if the doctors themselves were allowed to enter practice after the War not as well equipped as they might be to prevent and cope with disease.

Yours, etc.,

MARK WILKS, Surg.-Lieut. R.N.V.R.

DEBATING SOCIETY.

To the Editor of the GAZETTE.

SIR,—I should be very pleased to hear from any students who are interested in resuscitating the Debating Society in the Hospital.

Yours, etc.,

CYRIL DAVID BAKER.

TO DENTAL STUDENTS.

To the Editor of the GAZETTE.

SIR,—"Synoptic," in his letter in your last issue, complains that he has had no replies to his original letter published by you three months ago. If "Synoptic" were to write under his own name he would find that there were many members of the *Gazette* who would be only too willing to discuss his publications with him.

Yours, etc.,
"LETHARGY."

Guy's Hospital Cricket Club

RETROSPECT OF SEASON 1943.

WE are glad to be able to report a most successful season, probably one of the best for a long time. Contrary to the usual practice we had games every week throughout the season, in consequence of which we suffered heavily during July through holidays. Nevertheless, 21 matches were played, of which 13 were won, 2 lost and 6 drawn. The two defeats, by 46 runs and 6 wickets respectively, were at the hands of Metropolitan Police and London Fire Force, two of the strongest clubs in London.

Of the drawn games two were very much in our favour, two were at an interesting stage, and in two we just saved the game.

The most notable victories were against Woolwich Garrison, by 7 wickets; Beckenham, by 10 wickets; Buccaneers, by 3 wickets; Richmond, by 71 runs.

Against other hospitals we were victorious on every occasion except in the second Middlesex Hospital game at Chislehurst, which was drawn. Unluckily, the game against London Hospital was scratched owing to rain.

Results :—

v. Middlesex, at home. Won by 8 wickets.
v. K.C.H., at home. Won by 5 wickets.
v. St. Thomas', at home. Won by 58 runs.
v. St. Bart.'s, at home. Won by 58 runs.
v. Middlesex, away. Match drawn.
v. St. Mary's, at home. Won by 102 runs.
v. St. Thomas', at home. Won by 63 runs.

Our best score was 262 against Old Rutlishians; others over 200 were 235 for 4 against Woolwich Garrison, 207 for 8 against St. Thomas' Hospital, 209 for 7 against Richmond. Only once was our score under 100, and then there was one wicket still to fall; 202 was the only score over 200 made against us, and on eight occasions the opposing team were all out for less than 100 runs.

Probably the chief factor in our success was the presence of three outstanding all-rounders in the side—E. W. R. Alderman, E. G. Murphy and D. R. S. Saunders. Between them they took 113 wickets and scored 1,029 runs. Murphy headed the batting averages with 29.00 over sixteen innings. Saunders headed the bowling with 36 wickets, costing slightly over 8 runs apiece.

Murphy scored our only century, the first for two years. Alderman got the hat-trick once, and nobody can remember the last time that occurred. Other performances were :—

BATTING.

D. C. Boyd .. .. 83 *v.* Woolwich.
E. G. Murphy .. 62 *v.* Beckenham.
69 not out *v.* Public School Wanderers.
E. W. R. Alderman.. 57 *v.* "A" Div. Met. Police.
G. Thompson .. 56 *v.* Woolwich.
D. R. S. Saunders .. 58 *v.* Old Rutlishians.
D. J. Sheerboom .. 66 *v.* Old Rutlishians.
R. G. L. Brittain .. 53 *v.* Buccaneers.

BOWLING

E. W. R. Alderman.. 6 for 24 *v.* Beckenham.
6 for 28 *v.* St. Thomas's
D. R. S. Saunders .. 7 for 34 *v.* Richmond.
6 for 33 *v.* Public School Wanderers.

The fielding was at times very good and, on other occasions, unbelievably bad. R. G. L. Brittain kept wicket well most of the season; D. J. Sheerboom was outstanding at cover-point, E. G. Murphy in the slips.

Finally, mention must be made of Murphy's performance for United Hospitals. In six innings, with one not out, his average was 75, and in all matches he scored over 1,000 runs.

The following played during the season :—E. W. R. Alderman, G. W. Garland, E. G. Murphy, D. C. Boyd, D. R. S. Saunders, G. Thompson, L. D. Carton-Kelly, A. Brown, D. Nicholson, R. Finney, D. J. Sheerboom, C. S. Gardner, R. G. L. Brittain, P. Hildick-Smith, P. L. Brangwin, C. B. Clarke.

Lawn Tennis Club

THIS past season has been a disappointing one, in that, out of a total of nineteen fixtures, only nine were actually played. The reasons for the cancellations were diverse. On the other hand, we can truthfully say that, to an appreciable extent, the success of the United Hospitals and the London University were due to the Guy's representatives. In fact, an unbroken record was marred on two occasions, when the first VI was badly depleted of the best players, who were called away.

Tennis next year will depend on whether tennis-balls are available. New balls will be impossible to buy. But there is a chance to recondition used ones. If any reader would care to give their old balls to Mr. Kirby, he will arrange to have them renewed for Hospital matches next year.

Team.—D. E. Williams (captain), D. F. L. Cook, K. Y. Khong (secretary), R. Freeman P. E. Mars, R. G. Lomax, S. A. Marsh.

Results : Played, 9 ; won, 7 ; lost 2.

Hospital Information, etc.

Notices

DENTAL SOCIETY.

The following officers have been elected for the coming year :—

President	K. E. Pringle.
Hon. Sec.	P. C. S. Campion.
Asst. Hon. Sec. and Gazette Representative ..	A. Bridge.
Hon. Treasurer	J. A. Morrant.
Third Year Representative	J. Andrew.
First Year Representative	P. C. Matthews.
Dance Secretary	J. E. Dyke.

Pass List

CONJOINT BOARD.
FIRST EXAMINATION.
September, 1943.

Anatomy.

J. H. Apted	R. L. Edwards
I. A. Blackmore	A. L. Jeanes
C. D. Bulstrode	J. L. Jenman
R. W. Doy	N. M. Midgley
J. B. Eades	P. Read
M. E. P. Easton	J. Southgate

Physiology.

J. H. Apted	R. L. Edwards
I. A. Blackmore	J. L. Hardman
C. C. Bull	J. L. Jenman
R. W. Doy	N. M. Midgley
J. B. Eades	B. Wotton

Pharmacology.

L. W. Bowen	D. O'Keeffe
M. M. El Shinnawi	D. J. Rudman
R. R. W. Nichols	

Births

HARVEY.—On September, 21st, 1943, at Guy's Hospital, to Sheeplagh (née Phelps), wife of Squadron-Leader Warren Harvey, a brother for Janet.

Marriages

HAND-BOWMAN—McARTHUR.—On 18th September, 1943, at St. Peter's Church, Vere Street, W.1, Denis Hand-Bowman, Capt. A.D. Corps, to Margaret McArthur.

Deaths

FRY.—On 24th September, 1943, at Bexhill, following an operation, Augustine Cradock Fry, M.D., F.R.C.S., aged 75.

KNIGHT.—Previously reported missing, believed prisoner, now recorded killed in action 6th June, 1942, Major H. M. R. Knight, R.A.M.C., elder son of Dr. and Mrs. H. S. Knight, of The Grange, Tressillian Road, S.E.4.

LOCKE.—In September, 1943, Arnold Edgcombe Locke, Capt. R.A.M.C., Middle East Forces, only son of Mr. and Mrs. T. A. Locke, of Newquay.

STONER.—On 10th September, 1943 Harold B. Stoner, M.R.C.S., L.R.C.P., L.D.S.Eng., of Regency Square, Brighton, aged 73.

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

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PASSIM

WE hear that at the recent examinations "the gentlemen of Queen Square" have asked awkward questions about the National War Formulary, greatly to confusion of the occasionally uninformed candidate. Feeling that many students at the Hospital are, indeed, ignorant of the existence and nature of the Formulary, we are prompted to say a little about it; not entirely with the sordid motives of the examination candidate, but also, we hope, with some appreciation of the national importance of careful prescribing in war-time.

The National War Formulary was prepared in 1941 by a committee appointed by the Minister of Health; it is largely based on the Formulary for National Health Insurance purposes, but other works, such as the pharmacopœias of the larger hospitals have been consulted and the recommendations of the Therapeutics Requirements Committee of the M.R.C. as regards the omission and substitution of drugs have been followed as closely as possible. These recommendations are published in the M.R.C. War Memorandum No. 3 on "Economy in the Use of Drugs in War-time."

Briefly, the aim of the War Formulary is to provide a guide to the economical use of drugs for all those concerned in prescribing and dispensing medicines. A range of medicines sufficient for ordinary therapeutic purposes is provided, non-essential drugs are omitted and alternatives given for those which are unobtainable. Besides those medicaments which are in short supply, other economical issues are at stake. The time, space and labour involved in packing and transport are vitally important with the War at its present phase, when such economic factors as transport and shipping space may well decide the ultimate result. Some idea of the size of the problem may be obtained from the consumption of medicinal liquid paraffin at Guy's; this was in the order of 2,000–3,000 gallons a year. These figures, applied to other hospitals of an equal size, and extended to the multitude of modern drugs (most of them less bulky than liquid paraffin, it is true) indicate the large transport facilities needed.

All this makes life distinctly harder for the war-time doctor, and well-nigh intolerable for the unfortunate student of therapeutics. In peace-time the mass of pharmacological and posological minutiæ form quite a burden for the unqualified man who is unable to learn his detailed therapeutics by repeated reference and prescription. Nowadays, when alternatives have to be considered, and, for example, the Tinctura has to be translated to terms of Extractum siccum or liquidum, confusion abounds on all sides!

An interesting possibility in the realms of drug economy is the production of "home-grown drugs." The Pharmaceutical department has been experimenting in this direction with the growing of belladonna and hyoscyamus. Several references to their difficulties, work and progress have been made in our correspondence columns over the last eighteen months. A further letter from the Hospital Pharmacist is published in this issue, telling of very creditable results.

ON behalf of all Guy's men and women we offer congratulations to Surg.-Lieut. P. R. C. Evans, R.N.V.R., on being awarded the George Medal for gallantry in services to the wounded after his ship had been damaged by an explosion. Our readers will probably remember the accounts of his heroism published in the papers at the time and which we referred to in our "Passim" on April 17th.

Obituary

CECIL PRICE-JONES, M.B. (LOND.).

CECIL PRICE-JONES, who died recently at the age of eighty, qualified at Guy's more than fifty years ago. Shortly afterwards he succeeded his father in practice at Kingston-on-Thames, but he was never attracted by this form of Medicine and, following the early death of his wife, he gave up clinical work entirely. For some years he relinquished Medicine, but early in the present century he returned to Guy's to take part, under Professor Eyre, in the very active investigations then taking place in the Bacteriology Department upon Malta Fever. Like so many workers who have studied Brucella infections, Price-Jones contracted the disease and spent a year in a protracted convalescence. He then came under the influence of A. E. Boycott, at that time Gordon Lecturer in General Pathology at Guy's, who was carrying out research upon the hookworm anæmia of Cornish miners and the problem of blood regeneration. This experience determined the whole course of his subsequent career, for it led to his taking up the study of blood diseases. At the end of the last war, in which he served in France for some years as an Army pathologist, he joined Boycott's new department at University College Hospital. It was in this laboratory that he carried out most of his research in hæmatology, and from it that he spread the stimulating and encouraging influence over younger workers which made him the leader of the small, though active, group of London hæmatologists.

Price-Jones's name will be chiefly remembered for his persistent application of statistical methods to the practical problems of hæmatology. His careful studies of normal blood standards will probably long remain the yardstick for the recognition of the anæmias. But of even more importance, and of greater personal interest to Guy's men, was his painstaking study of red-cell diameters from which was derived the well-known "Price-Jones Curve." With this he established the best diagnostic criterion for the anæmia described at Guy's by Addison seventy years before.

Price-Jones was a man of broad interests and wide talents. He was a first-class 'cellist and a good pianist. His water-colours and pencil drawings were both charming in their subjects and executed with artistic skill of a high order. Some were painted during his sailing holidays—for long he had a boat in which he explored the lesser frequented parts of the English coast; others were records of his visits to the Continent and Africa. For some years before his death his invalidism had caused him to become somewhat of a recluse in his house at Radlett, but any of his friends who visited him there had the delightful experience of contact with a breadth of culture and attainments unfortunately less common to-day than it was in the more leisured days when he was a young and active man. Price-Jones had more personal sorrow than falls to most men, but he also had the good fortune to enjoy many years of life in which he had the time and opportunities to cultivate his unusual talents.

Correspondence

HOME-GROWN DRUGS.

To the Editor of the GAZETTE.

SIR,—Some months ago I reported that the belladonna growing in the Park promised a good crop. Harvesting and drying has now been completed and the very gratifying result is some 21½lb. of dried and powdered leaves of very good colour. A preliminary assay on a sample indicates an alkaloidal content of 0.45 per cent., which is about one and a half times the minimum B.P. requirement. It is estimated that this quantity of drug will supply, in the form of tincture, the entire needs of Guy's for at least eighteen months. The monetary saving is not very great, possibly £10 or so; but the fact that our supplies of at least one very scarce drug are assured for some time to come is probably of more value to the Hospital than can be represented by mere £. s. d.

The whole of the work of cultivation has been done in their spare time by Messrs. B. G. Gotts, S. F. Izzard and J. S. Rutter, of the Pharmaceutical Department, assisted from time to time by the advice and labour of various other members of the Hospital staff.

Yours, etc.,

J. MOORE,

Guy's Hospital, S.E.1. Chief Pharmacist.

The Hysterical Nature of So-called Pernicious Vomiting of Pregnancy

By Sir ARTHUR HURST, M.A., D.M. (Oxon.), F.R.C.P.,
Consulting Physician to Guy's Hospital.

(*Reprinted from "The Clinical Journal" by kind permission of the Editor.*)

As vomiting occurs in more than 50 per cent. of women in the early weeks of pregnancy it can be regarded as physiological, though I expect it is sometimes hysterical when it is not the first symptom, as every woman expects to be sick when she first becomes pregnant, and nothing is more likely to produce an hysterical symptom in a suggestible person than expectation. In about one case per thousand in hospital patients, and rather more frequently in better-class practice, vomiting occurs after every meal, and even apart from meals, and persists longer than the usual period of six or eight weeks. It is then referred to as "the pernicious vomiting of pregnancy" or "hyperemesis gravidarum."

For thirty years I have been convinced that so-called pernicious vomiting is always hysterical (Hurst, 1914). But the condition is still insufficiently understood, as while there should be no mortality, the Registrar-General's *Statistical Review* shows deaths from hyperemesis gravidarum amounting to sixty in 1930, fifty-one in 1936 and fifty-two in 1937. The old belief that a toxic form exists was rejected by the Ten London Teachers from their "Midwifery," now in its seventh edition, between the appearance of the second edition in 1920 and the third in 1925. This, I expect, was largely due to the influence of Mr. J. S. Fairbairn, who told me when I published my paper on the "Hysterical Nature of so-called Pernicious Vomiting of Pregnancy" in 1922, that he was in entire agreement with me, and that in the previous ten years he had not found it necessary to empty the uterus in a single case. The latest editions of ten other modern British and American text-books of midwifery, however, still discuss the differential diagnosis between the toxic and nervous forms of pernicious vomiting of pregnancy. The signs relied upon for the recognition of the supposed toxic variety are a pulse rate persistently over 100, marked loss of flesh and furring of the tongue. Eden and Holland (1937) add that the signs of the "neurasthenic temperament must be sought for," but they do not say what they mean by neurasthenia or what are the signs of the neurasthenic temperament.

Gibberd has rewritten the chapter on hyperemesis gravidarum in the 1943 edition of his "Midwifery" in the light of Sheehan's pathological observations. He now teaches that the very rare cases in which Korsakow's syndrome of peripheral neuritis with mental symptoms develop are toxic in origin, because of the resemblance of the clinical picture and pathological findings to those produced by alcohol. But it has been conclusively proved that alcohol is never *per se* the cause of the syndrome, which is really the result of the associated deficiency of vitamin B. It seems obvious, therefore, that when it develops in the late stages of hyperemesis gravidarum it is caused by vitamin deprivation secondary to the vomiting, and not by a hypothetical toxin.

Whitridge Williams (1906) believed that there was no clinical distinction between the nervous and toxæmic cases, and that the only reliable means of diagnosis was by estimating the ammonia coefficient of the urine, *i.e.* the percentage of the nitrogen present in the urine as ammonia. He regarded an increase to 10 as pointing infallibly to toxic vomiting; it was to be regarded as an urgent indication for the prompt termination of pregnancy, as death would otherwise inevitably occur within a few days. But the chemical evidence is available only for a few days, the rise in the ammonia coefficient being sudden and rapid. Consequently if such a case were seen just before the coefficient began to rise it would be called nervous and would be cured by appropriate measures, whilst if seen a few days later for the first time, when the index had risen to 10, it would be called toxæmic and the uterus would be emptied.

The unreliability of both clinical and chemical diagnostic criteria for the diagnosis

of " toxic " vomiting of pregnancy is shown by the following case, which was described in my paper of 1922 :—

A case of so-called Pernicious Vomiting of Pregnancy with High Ammonia Coefficient, cured by Psychotherapy.—G. B——, aged thirty-two, became pregnant about the middle of December, 1919. Three weeks later she began to vomit. In addition to being sick after meals she vomited large quantities of bitter yellowish-green fluid at all times of the day. She was admitted into a provincial hospital, where her abdomen was explored, as it was thought she might have an extra-uterine gestation, but nothing abnormal was found. She continued to vomit as frequently as ever and felt much weaker on her return home. She was kept in bed, but as no improvement occurred, she was admitted into the obstetric ward at Guy's Hospital on March 7th, 1920. A diagnosis of pernicious vomiting of pregnancy, toxæmic in origin, was made, as Dr. J. H. Ryffel found the ammonia index 28 on the day of admission ; there was a large amount of diacetic acid in the urine, but no albumen or sugar. I saw the patient on March 9th at 2 p.m. Her pulse, which had not fallen below 120 since admission, was now 136. She was very emaciated and her skin was dry and inelastic. Her tongue was covered with dark brown fur and was very dry. She had vomited everything she had been given, fluid as well as solid, during the past week, and had continued to vomit since admission, though she had had saline solution by rectum and nothing at all by mouth. Her mind was perfectly clear. She told me that when she began to vomit early in her pregnancy her father had said to her, " You will have a bad time of it, as your mother vomited all the time she was carrying you." I explained to her that there was no good reason why she should have continued to vomit after the first six weeks of pregnancy, in which vomiting is normal, but that what her father had said to her had given her the idea that the vomiting would continue, and such a suggestion, coming at such a time, was all that was needed to lead to the condition she was now in. We talked about her illness for ten minutes, at the end of which I had succeeded in convincing her that she would not vomit again. I returned to her at 4 p.m., and watched her eat some buttered toast and tea which she had herself chosen for her first meal. She felt no inclination to vomit. She had a good supper, but vomited her breakfast next morning. She was then transferred to the better psychological atmosphere of my ward, and had dinner with steak and pudding, which she kept down. She had no further trouble, and left the hospital on April 8th, having gained 16 lb. in weight. The ammonia coefficient, which had been 28 on March 7th, had fallen to 11.7, 10 and 9.5 respectively on March 16th, 22nd and 29th, and there was no diacetic acid or other abnormality in the urine. The pregnancy ran a normal course and a healthy daughter was born at full term.

About the middle of August, 1921, eleven months after the birth of her first baby, she again became pregnant, greatly to her indignation, as she had declared on discharge from the hospital that she would never have another child if she could help it. She at once began to vomit, and the vomiting became so severe that her own doctor discussed the question of terminating the pregnancy artificially. On October 18th she came to the hospital to see me. It was clear that the vomiting was again hysterical, and that this time it was caused by the subconscious desire to end an unwished-for pregnancy. Without difficulty I made her realise that the vomiting would cease as soon as she made up her mind that she had to face her troubles and go through with the pregnancy, and that vomiting would not be regarded as an excuse for ending it. She came into the hospital the next day, and did not vomit again although she was at once given a full diet. She remained in hospital for a fortnight and was then discharged, having remained free from digestive symptoms the whole time. There was no return of vomiting and a healthy boy was born at full term.

The following case,† which was published recently among a series of " selected case histories " by members of the Section of Obstetrics of the Massachusetts Medical Society (1942), is quoted, as it offers an interesting contrast with my case of twenty years ago.

A Case of Fatal Vomiting in Pregnancy.—A primipara, aged twenty-four, entered hospital at the end of the third month. She had been vomiting practically everything for the four weeks before admission ; her weight was 90 lb., which represented a loss of about 40 lb. The pulse was 140. She was given 10 per cent. glucose solution intravenously, and four days later it was decided to induce abortion. In spite of this she died four days later. There was no post-mortem.

† *Clinical Journal*, 1943, p. 77.

The anonymous author points out that this case shows that, "when poorly treated, the nausea and vomiting of pregnancy may still become pernicious and even result in death. . . . Had the patient consulted a physician when the nausea and vomiting appeared, and had simple home remedies proved of no value, hospitalisation should have been advised. The treatment then would have been rest in bed, sedation, intravenous glucose (2,000 c.c. a day), thiamin chloride intramuscularly in large doses and no food by mouth for several days. Small feedings through a tube might have been necessary." The severe loss of weight and the rapid pulse when admitted were regarded as indicating that abortion was the only possible treatment, though it proved unavailing. I think that recognition of the hysterical nature of the vomiting with simple, but convincing, psychotherapy would have saved her life without resorting to abortion.

It is obvious from the history of my case that no reliance can be placed on either the clinical or the chemical diagnosis of toxæmic vomiting of pregnancy. I do not, in fact, believe that such a condition exists, apart from the vomiting associated with eclampsia and acute hepatic necrosis. It should be noted, however, that jaundice, caused presumably by subacute hepatic necrosis, may also result from hysterical vomiting, and that it rapidly disappears with an adequate diet. The high ammonia index and the great excess of diacetic acid present in my patient's urine were clearly not caused by toxæmia, but were the result of starvation and dehydration. The same symptoms and urinary changes do not occur in fasting, as water is drunk. But in "pernicious" vomiting so much water is lost that the acid products of forced metabolism cannot be excreted with sufficient rapidity and ammonia is formed to neutralise them.

It is clear that the division into the nervous and toxæmic classes is fallacious. All cases are nervous; but the word "hysterical" should be substituted for "nervous," as the condition is typically hysterical, caused by suggestion and curable by psychotherapy. The physiological vomiting of the first weeks is easily perpetuated and exaggerated as hysterical vomiting by suggestion. It can be instantaneously stopped by the simplest form of psychotherapy—explanation and persuasion, without recourse to diet or drugs, which act too, by suggestion. To empty the uterus must similarly act by suggestion, as the patient naturally expects to recover when what she regards is the cause of her vomiting is taken away, and when vomiting continues and death occurs in spite of the operation, as in four out of Whitbridge Williams's nine cases, and in the recent American case quoted above, the suggestion has not proved sufficiently powerful, probably because the patient was not previously told that it would certainly cure her.

The occurrence of hysterical vomiting in one pregnancy is very likely to suggest a recurrence in later pregnancies. This occurred in both of the cases investigated by Gilliatt and Kennaway (1918) and in my case described above.

Even those authors who regard many of the severest cases as hysterical rarely have the courage of their convictions. Isolation and encouragement are rightly recommended, but bromide—the old panacea for psycho-neuroses—is prescribed, and, instead of beginning at once with a full diet, two-hourly feeds of peptonised milk or albumen water are given, and, in severe cases, resort is had to complete starvation with glucose and saline solution by rectum.

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Extra-Renal Uræmia

Clinical Lecture (abridged) by A. A. OSMAN, delivered at Guy's Hospital, August 27th, 1943.

GENTLEMEN,—For may years it was believed that a persistent increase in the concentration of urea in the blood was always due to disease of the kidneys. It was not until 1912 that it was observed that the blood urea may be considerably raised in such conditions as cholera (Froin and Marie, 1912), summer diarrhœa in infants (Nobécourt, Bidot and Maillet, 1912), and in high intestinal obstruction (Tileston and Comfort, 1914), in the apparent absence of renal disease, and certainly in the absence of demonstrable structural changes in the kidneys. A distinction was thus made between uræmia (or azotæmia) due to renal disease—renal uræmia—and that which occurred without evident renal disease—so-called extra-renal uræmia.

During the past thirty years extra-renal uræmia has been found in an increasing number of different disorders so that its importance in clinical medicine is considerable. Its prevalence, indeed, is so great that it is possible to cite now only some of the more important conditions in which it may occur. Such are :—

1. Vomiting, severe and protracted from any cause, but especially in high intestinal obstruction, hyperemesis gravidarum and in the renal uræmia of Bright's disease (*i.e.*, an extra-renal uræmia may be imposed upon an existing " renal " uræmia).
2. Intestinal obstruction without vomiting, but with retention of fluid in the intestinal tract—acute dilatation of the stomach.
3. Diarrhœa, severe and prolonged, from any cause.
4. Gastro-intestinal hæmorrhage (severe)—hæmatemesis or melæna.
5. In " shock," whether due to trauma, surgical operations, associated with extensive burns, or in cardiac infarction.
6. Acute liver disease—acute yellow atrophy and the so-called " hepato-renal syndrome."
7. Diabetic acidosis.
8. Addison's disease.
9. Fevers.
10. Sepsis—empyema, peritonitis, etc.
11. Heart failure.
12. Peripheral circulatory collapse—associated with any of the above or with other disorders.
13. Alkalosis—as in the alkaline treatment of peptic ulcers.

The clinical features of extra-renal uræmia are often difficult to define since they are apt to be overshadowed by those of the accompanying and primary disorder. Irritability, depression and insomnia, and an unpleasant, and sometimes " metallic," taste in the mouth are common early symptoms. Lassitude and lethargy, leading to stupor and eventually to coma, are also among the earliest and most constant symptoms. There may be a dull headache, but severe headache and convulsions do not occur. Involuntary muscular twitchings have been observed as in renal uræmia, but they are rare. Vomiting, diarrhœa, pruritus and urinous odour in the breath may all occur, but are uncommon. The clinical picture, in fact, is that of mild renal uræmia (" true," or " latent," uræmia, as seen in urinary obstruction) without the symptoms due to an associated hypertension—viz., retinitis, amaurosis, violent headaches and convulsions (the " pseudo-uræmia " of Bright's disease).

The typical biochemical picture in extra-renal uræmia is a moderate azotæmia often associated with alkalosis and hypochloræmia ; urine of high specific gravity and urea content, but containing little or no chlorides. Oliguria is usually severe. These findings seemed at first to be the exact opposite of those so characteristic of renal uræmia, namely, a high degree of azotæmia associated with an acidosis, a normal or hyperchloræmia ; urine of low specific gravity and urea content, and high or normal chloride concentration. In fact, the comparatively slight azotæmia (blood urea not usually

exceeding 80–120 mgm. per 100 c.c.), the high specific gravity and urea content of the urine, and absence of albuminuria and formed elements in the urine, together with the results obtained with the comparatively crude methods of estimating renal function then in use, combined to emphasise the apparently non-renal nature of this type of uræmia. Further experience showed, however, that not infrequently the blood urea reached much higher levels—400 and 500 mgm. per 100 c.c.—whilst more careful observation of the urine revealed traces of protein and an excess of red blood cells and casts in an unexpectedly high proportion of the patients. Gradually it became apparent, too, that the alkalosis and hypochloræmia were due to the vomiting and dehydration, and so forth, whilst the high specific gravity of the urine was, when considered in relation to the marked oliguria, only apparently raised and was, in fact, actually below normal. Observations on the nitrogen excretion in the urine showed that in most of the conditions under consideration protein katabolism is markedly increased though not sufficiently to account for the whole of the azotæmia. Increased protein katabolism does, however, explain the high urea content of the urine in this disorder. The evidence, in fact, pointed strongly to a diminution in renal function as the cause of the azotæmia, and this was finally established with the introduction of more delicate methods of testing renal function. The term " extra-renal," as applied to uræmia or azotæmia, would therefore seem to be a misnomer and should be abandoned.

There is, of course, one striking difference between the type of uræmia we are now discussing and that of frank renal disease, and that is the absence of demonstrable structural alterations in the kidneys other than those generally found in these organs in subjects dying from any protracted illness without obvious disease of the kidneys. Though originally the main argument of those who believed in the non-renal nature of this type of uræmia, absence of permanent structural changes in the kidneys can no longer be held even to support this view when it is recalled that naturally acquired, and experimentally produced, nephritis with clinical and biochemical " uræmia " has been observed in both man and animals without correlevant structural changes.

The conclusion would seem to be that in so-called extra-renal uræmia we are dealing with a " functional," as distinct from a structural, disorder of the kidney, and that the older view that uræmia is always essentially renal in origin, is correct. Even so, it is still necessary to consider by what mechanism renal function becomes diminished in what we may now more accurately refer to as " functional " uræmia.

Jegerhs and Bakst (1938) maintain that all examples of this disorder can be explained on the basis of one or more of the following fundamental mechanisms :—

(*a*) Fall in blood pressure.
(*b*) Low blood chlorides and sodium.
(*c*) Dehydration.
(*d*) Increased protein katabolism.
(*e*) Liver damage.
(*f*) Local renal failure—*i.e.*, a toxic nephritis.

It is not possible now to discuss the role played by these several factors (*a–e*) alone and together. It will suffice to remark that all are known to cause a moderate azotæmia though not enough to account for the whole of that commonly found. Of toxic nephritis (*f*) there is no evidence whatever. Black (1942), however, points out that these mechanisms are not really " fundamental," in that most of them can be explained on the basis either of diminished blood volume, or electrolyte change, or both.

By far the most important factor which influences renal function from moment to moment both in health and in disease is the amount of blood flowing through the kidneys. A diminution in the total quantity of blood in circulation, whether it be actually lost from the body or temporarily held up in the splanchnic blood depot or elsewhere, must result in a diminished return to the heart. As a consequence there is a fall in the cardiac output and a diminished blood flow through all the organs of the body. The heart itself and the brain will, owing to their vital importance, maintain (through the mechanism of arteriolar constriction) their normal blood flow for some time at the expense of less immediately important organs such as the kidneys. In the condition we are discussing to-day, however, it is the peripheral circulation which generally fails, and not primarily the heart. In nearly all the " causal " disorders I have already enumerated you will observe that peripheral circulatory collapse is a conspicuous feature. The latter is already familiar to you under

its clinical name "shock," and it is this condition apparently which is the chief cause of "functional" uræmia.

We have now been able to trace the ætiology of this hitherto puzzling condition at least so far that it is possible to institute a rational line of treatment, though, of course, we have not yet answered the question—what causes shock? Treatment must obviously be directed to restoring the volume and the electrolyte composition of the blood to normal as soon as possible, and this is achieved by giving appropriate quantities of fluids and salt by one route or another. Unfortunately it would take too long to enter into the very important details of treatment now, though it may be remarked that the results are often highly satisfactory in contrast to those which obtain in the treatment of uræmia associated with structural changes in the kidneys.

With regard to the question, what causes shock? I would refer you to a very important and recent paper by Green (1943), who has isolated from the striated muscle of traumatised rats a substance which, when injected into normal rats, reproduces all the clinical features and post-mortem changes associated with "shock," and which he provisionally terms "M.S.F."—or the Muscle Shock Factor. Furthermore, Green adduces evidence that the greater part of the activity of M.S.F. is probably due to adenosine triphosphate.

It cannot be said that the cause, or causes, of shock either in man or in animals has yet been established, and no such claim is made, but you will agree that this work constitutes a remarkable advance in knowledge.

This, Gentlemen, is, very briefly, the history of a serious and puzzling clinical syndrome first recognised only thirty years ago. Although the views I have just outlined concerning its ætiology, pathogenesis and treatment, may not be final they are certainly a tribute to the devoted efforts of a numerous band of reasearch workers in clinical medicine and in biochemistry. You will find it an agreeable as well as an instructive experience to follow for yourselves the development of this subject in the literature.

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Sport

Rugby

GUY'S PAST *v.* PRESENT.

(At H.O.P. on September 25th.)

Guy's opened their centenary season against a team of Past Guy's players which had been raised by Mr. G. A. R. Winston. A large number of supporters came down, including Mr. C. S. Bongand, the Middlesex president; Dr. A. Allport, an old Guy's man, who played for England in 1894; and Dr. J. H. Busteed. From these and many others congratulations and best wishes for the season were received. A telegram of congratulation was sent by Mr. J. C. B. Wilkins, president of Kent and of the London Rugby Union.

Lee introduced two new players—P. C. S. Campion, who captained the Tunbridge Wells side three years ago, came in as wing forward, and another Tunbridge Wells player, E. W. Graham, succeeded Lillywhite at stand-off. C. Ziervogel, who was awarded his "blue" in 1935, made a welcome return to the pack.

The score flatters the victors, for in the first half the Past side had its full share of the ball, the half-time score being 5-3 against them. Their captain, Dr. R. A. P. Hogben, who led his team well, kicked a penalty goal for his side early in the game. From then Guy's steadily established their superiority, and tries were scored by P. D. Harvey, R. G. L. Brittain, N. K. Macrae-Gibson (two each) and E. W. Graham. Gullick kicked well and converted six of the seven tries. The fact that four were scored by forwards is an indication of their excellent backing up, which was a feature of the game.

Score: Past, 1 penalty goal, 3 points; Present, 6 goals, 1 try, 33 points.

Teams.—Past: T. L. T. Lewis; J. M. Hanson, J. Ebsworth, J. Phillips, R. F. Camp; W. H. Lillywhite, N. I. Scott; J. A. R. Smit, D. G. White, J. D. Averall, A. G. Albers, A. S. Carruthers, R. A. P. Hogben (captain), M. G. Evans, J. L. Harrington.

Present: G. Hildick-Smith; J. N. Micklem, D. M. Strathie, N. K. Macrae-Gibson, A. C. Macrae-Gibson; E. W. Graham, R. N. H. Vann; A. Batty Shaw, A. B. Lee (captain), R. G. L. Brittain, C. Ziervogel, D. L. Gullick, P. D. Harvey, C. Vidot, P. C. S. Campion.

List of Entries

List of Entries
Guy's Hospital Medical School

October, 1943.

1ST YEAR STUDENTS.

Name.	*School.*
Argyle, G. V.	Marlborough Coll.
Beswick, E.	Hutton Gram. Sch.
Boyars, A.	University Coll. Sch.
Brewin, T. B.	Rugby.
Carreras, J.	Douai Sch.
Chadwick, P.	Queen's Coll., Taunton.
Christie, B. G. B.	Ampleforth Coll.
Clark, D. W.	College Secondary Sch., Swindon.
Davies, I. B.	Tech. Sch., Neath.
Evans, D. L. P.	Christ Coll., Brecon.
Gale, C. W. C.	Ardingly Coll.
Gilbert, M. C.	Cranbrook Sch.
Glenn, R. W.	Tonbridge Sch., Kent.
Grummitt, M. W. J.	Maidstone Gram. Sch.
Hampshire, W. H.	Newcastle Royal Gram. Sch.
Handy, R.	Enfield Gram. Sch.
Hardman, H.	Preston Coll.
Harper, G. W. S.	Monkton Combe Sch., Bath.
Harrison, D. F. N.	Newport High Sch.
Heber, K. R.	Ellesmere Coll., Shropshire.
Hutchings, D. H.	Kingswood Sch., Bath.
Hume, E. M.	Lancing Coll.
Jackson, M. C. H.	Aldenham Sch., Elstree.
Jacobs, L.	Univ. of Chicago.
Johnston, I. G.	Eltham Coll.
Jones, G. L.	Ystradgynlais Co. Sch.
Jones, W. T.	Rossall Sch.
Laurence, G. A.	Nottingham High Sch.
Lewis, D. M.	Neath County Sch.
Lewis, E. C.	The King's Sch., Chester.
McGuire, E. J.	Epsom Coll.
McLauchlan, A. E.	Ipswich Sch.
Menzies, C. J. G.	Tonbridge Sch.
Phillips, A. H.	Rhondda Co. Sch.
Phillips, A. R.	Mill Hill Sch.
Pierce, G. F. M.	The King's Sch., Canterbury.
Poole, P. B.	The King's Sch., Canterbury.
Scott, I. A. W.	Cheltenham Coll.
Stradling, A. W.	Newbury Gram. Sch.
Skinner, T. G.	Ardingly Coll.
Tenebaum, L.	Maesteg Secondary Sch.
Vance, J.	Merchant Taylors Sch.
Williams, J. J.	Kingswood Sch., Bath.
Wynell-Mayow, D.	Reading Sch.

2ND YEAR STUDENTS.

Ager, D. A.	Culford Sch.
Craigen, A. A.	Epsom Coll.
Garrett, J. P.	Colfe's Gram. Sch.
Gothilf, R. L.	Hackney Downs Secondary Sch.
Herbert, J. L.	Brynmawr Co. Sch.
Larsen, R. T. F.	Stowe Sch., Buckingham.
Mills, C. P.	Archbishop Holgate's Gram. Sch., York.
Owen, J. T.	Ystradgynlais Co. Sch.
Silkoff, B. J.	Davanent Foundation Sch.
Simpson, K.	Reigate Gram. Sch.
Vale, R. J.	Kingswood Sch., Bath.
Williamson, A. W. R.	Bradfield Coll.

ENTRIES FOR CLINICAL PERIOD OF STUDY.

October, 1943.

Name.	*School.*
Astle, W. E. C.	Emanuel Coll., Cambridge.
Baker, A. P.	Clare Coll., Cambridge.
Besterman, E. M. M.	Trinity Coll., Cambridge.
Braddock, G. T. F.	Christ's College, Cambridge.
Bulleid, J. A.	Trinity Hall, Cambridge.
Burns, T. H. S.	Keble Coll., Oxford.
Crossley, J.	Emanuel Coll., Cambridge.
Davies, D. G. L.	Univ. Coll. Cardiff.
Haas, L.	Trinity Coll., Cambridge.
Jefferson, K. E.	Clare Coll., Cambridge.
Lambert, F. R.	Emanuel Coll., Cambridge.
Lessof, M. H.	Kings Coll., Cambridge.
May, W. D.	Christ Church, Oxford.
Missen, G. A. K.	St. Edmund Hall, Oxford
Moffatt, J. L.	St. John's Coll., Cambridge.
Morton Palmer, J.	Jesus Coll., Cambridge.
Rooney, J. F.	Jesus Coll., Cambridge.
Selka, R.	Clare Coll., Cambridge.
Woodman, G. M.	St. Edmund Hall, Oxford.
Van' t Hoff, W.	Queen's Coll., Cambridge.

Guy's Hospital Dental School

October, 1943.

PRE-MEDICAL L.D.S. AND 1ST YEAR B.D.S. STUDENTS.

Name.	*School.*
Baird, H. M.	Merchant Taylors Sch.
Derry, J. D.	Monkton Combe, Bath.
Dyer, H. E.	Price's Sch., Fareham.
Farrow, J. C.	Archbishop Holgate's Gram. Sch., York.
Furnival, C. N.	Slough Gram. Sch.
Griffiths, P.	Highgate Sch.
Harber, M. W.	Sidcup Co. Sch.
Harris, J. B.	Kelly Coll., Tavistock.
Keeling, J. H.	St. Andrew's Coll., Grahamstown.
McLean, J. W.	St. Paul's Sch.
Minton, D. K.	Nantyglo Sec. Sch.
Phillips, G. G.	East Grinstead Co. Sch.
Price, T. C. J.	Beaumont Coll.
Rees, D. L.	Port Talbot Secondary Sch.
Richards, L. G.	Gravesend Co. Sch.
Rowland, A. P.	Hackney Downs Sec. Sch.
Saunders, B. S.	Malvern Coll.
Thiel, R. D. F.	Brighton Coll.
Tucker, P. H.	Kimbolton Sch.
Tustian, R. B.	Swansea Gram. Sch.
Walker, K. M.	Rishworth Sch., nr. Halifax.
Walker, T. K.	Haberdashers' Askes' Hampstead Sch.
Watson, C. B. H.	Marlborough Sch.
Whitelegg, J. G.	Sutton Co. Sch.
Williams, G. P. J.	City of London Sch.
Williams, J. D.	Dover Co. Sch.
Wright, P. J.	Ampleforth Coll., York.

1ST YEAR L.D.S. AND 2ND YEAR B.D.S. STUDENTS.

Citron, K. M.	Taunton Sch., Taunton.
Engelsman, B.	St. Olave's Gram. Sch.
Hampton Smith, P.	Westminster Sch.
Nelson, I. A.	Purley Co. Sch.
Rabinovitz, D.	Central Foundation.
Rosen, L. A.	Davenant Foundation Sch.
Rowe, A. H. R.	King Edward VI Sch., Southampton.
Tulley, W. J.	Churcher's Coll., Petersfield, Hants.
Waller, D. F.	Dulwich Coll.

Hospital Information, etc.

Dental School Annual Dance

The Guy's Hospital Dental School Annual Dance will be held at Grosvenor House, Park Lane, on Friday, November 12th, 1943, continuing from 8 p.m. to 1 a.m. The cost of tickets is 10s. 6d. each.

In view of war conditions the wearing of evening dress will not be essential, and will be left to the discretion of the individual.

It is regretted that restrictions have made catering of any kind impossible, but waiters will serve drinks and the bar is available.

It will be appreciated that the organisation of such a dance presents many difficulties at the present time and numbers have to be limited; therefore those wishing to be present should apply as early as possible, giving details of any arrangements they wish to make for reserving tables.

While this is essentially a Dental School function, we wish to extend a welcome to any present or past members of the Hospital.

JOHN E. DYKE,
Hon. Dance Sec.

Pass List

UNIVERSITY OF LONDON.
1ST EXAMINATION FOR MEDICAL DEGREES.
July, 1943.

K. Anderson
K. A. Baker
A. S. Bligh
A. G. Chalmers
A. R. Davis
J. R. Deacon
C. J. Earl
E. W. Graham
J. R. Greaves
A. K. Hancock
A. W. Hilliam
N. R. Howells
S. A. Jolliffe
J. E. H. Lahaise
W. G. Lewis
R. A. J. Mayhew
R. A. Miller
D. F. Potter
H. H. Richards
P. Ronchetti
P. A. Shave
E. J. Stafford
F. R. H. Wrigley

The following Students have completed the External First Medical Examination :—

J. T. Cecil
A. J. Heber

The following Higher School Candidates have qualified for exemption from the First Medical :—

D. C. Deuchar
H. H. B. Perkins
J. L. Warren
E. Killey
H. R. C. Riches

Guy's Hospital Dental School

PRIZE EXAMINATIONS, 1943.

The following awards have been made :—

Newland-Pedley Medal and Prize for Operative Dentistry.
P. C. Grummitt .. Medal and Prize.

Final Year Prize.
J. R. Dimock .. Prize.
P. C. Grummitt .. Certificate.

Prize in General Anatomy and Physiology.
B. M. Bilton } Bracketed equal.
J. S. Rose .. } Prize divided.

Prize in Special Anatomy and Physiology.
H. S. M. Crabb .. Prize.
P. C. Hanley .. Certificate.

Prize in General Medicine, including Medicine, Surgery, General Pathology and Bacteriology.
P. C. Grummitt .. Prize.

David Frank Sturdee Prize for Dental Prosthetics.
R. T. Lowein .. Prize.
J. C. Scholfield .. Certificate.

Second Year Prize in Dental Subjects.
No award.

Awards

George Medal

Surg.-Lieut. P. R. C. Evans, R.N.V.R.

M.B.E. (Military Division).

Capt. (Temp. Major) A. R. Clarke.

O.B.E. (Military Div.).

Major (Temp. Lt.-Col.) P. T. L. Day, R.A.M.C.

Mentioned in Dispatches

The undermentioned have been mentioned in recognition of gallant and distinguished services in North Africa :—Captain (Temp. Major) B. Holden, R.A.M.C., Captain C. D. Farris, R.A.M.C., Major (Temp. Lieut.-Col.) H. H. Kenshole, R.A.M.C., Captain (Temp. Major) W. L. Ogle, R.A.M.C., Major E. C. Zorab, R.A.M.C.

Sqdn.-Ldr. M. O. Richardson, R.A.F.
Wing Comdr. R. M. Outfin, R.A.F.

Prisoner of War

Major P. B. Hanbury, R.A.M.C.

Casualties

Previously reported missing, now reported officially presumed lost at sea: Captain E. J. A. Needham, R.A.M.C.

Previously reported missing, believed prisoner of war, now recorded killed in action June, 1942, Major H. M. R. Knight.

Change of Address

C. S. Darke, Lieut., R.A.M.C., 257891, No. 3 General Hospital, East Africa Command.

H. R. W. Franklin, M.B., B.S., City General Hospital, Gloucester.

R. P. Hancock, Captain, A.D. Corps, 123736, c/o Grindlay's Bank, Bombay.

Births

NEUSTATTER.—On September 24th, 1943, at Beaconsfield, to Molly (née Clutton-Brock), wife of Major W. L. Neustatter, R.A.M.C.—a daughter.

SYMMONS.—On September 14th, 1943, at the Blenheim Nursing Home, Wadebridge, Cornwall, to Jeanne (née Edmonds), wife of Lieut.-Commdr. R. Symmons (D.), R.N.V.R. —a son (Martin Trevor).

Marriages

BROCKLEBANK—RENDELL. — On September 25th, 1943, at Netley Abbey, John Alfred Brocklebank, Major, R.A.M.C., to Winifred Rosa Rendell, of Edmonton, Alberta.

SCARLETT—MORTON.—On October 14th, 1943, at the Presbyterian Church, Bromley, Kent, James H. Scarlett to Clare Dunlop Morton.

Deaths

COCK.—On October 9th, 1943, at The Well House, Appledore, Kent, Frederick William Cock, J.P., M.D., F.S.A., aged eighty-five.

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE appointment of house officers must always be a matter of great difficulty, which is certainly not simplified in the least by present-day conditions. More than ever well-deserving applicants (and their number has not decreased) are refused and given posts on the Sector. Not that these are of necessity any inferior from the point of view of experience to those at Guy's itself, but they do not carry the same professional respect and recognition which is accorded to anyone who has been "a houseman at Guy's." It has become especially important recently that the most capable men should be chosen owing to the limited period allowed before entering the Services. Should anyone be misjudged and sent beyond the immediate ken of Guy's his chance of redeeming this mistake in the six months at his disposal are remote and his connection with the Hospital may well be broken for good.

Until quite recently the selection of house officers was carried out entirely by the Medical Committee. Criticism was offered that as clinical teaching had been split up it was impossible for the members of the Senior Staff on this committee to come into sufficient personal contact with the students to give adequate opinions. Resulting from this a Medical sub-committee has been formed, consisting of the Sub-Dean at each base hospital and the registrars, whose duty it is to compile a list of recommendations for the approval of the Medical Committee. They are to be congratulated on dealing so fairly with what must at times be an invidious task. Seldom does it happen that any genuine objections are raised even by contemporary students who are usually able to give a shrewd opinion as to an individual's ability. Yet the chances even the registrars have for following progress are less than in pre-War days. Not only is the clinical period shorter, but students are frequently moved from place to place and the Registrar is confronted with ever larger firms.

This last has had an unfortunate result on the outlook of students and a popular misconception has grown up, especially in the early clinical period, that to push oneself forward is to shine, that without so doing one will remain unnoticed in the background. It is a view which credits the Junior Staff with small powers of observation and does scant justice to the trouble they take to give their firms as a whole the best they are able. But more unfortunate it leads to a small amount of petty ill-feeling amongst fellow students; competition is set up, but is more spiteful than stimulating and choice epithets in no way improve the situation. Were it more generally realised that such misdirected enthusiasm leads nowhere, that unhappy state of "sign-up consciousness" would be eradicated.

House appointments customarily start at the beginning of February, May, August and November—times which, unfortunately, do not always run conveniently with the announcement of various examination results. This has commonly been the case with the London University Board whose pass-lists are often published shortly after the start of one of these periods, with the result that unfortunate candidates who do not happen to have qualified in the Conjoint examination shortly before have to spend part of their limited allowance of hospital appointments off the Sector. The next list of house officers is being held over so that these cases can be included. On this occasion it is only a matter of two or three days, but it would appear to be a principle which could be extended. As the particular periods mentioned do not apply to Guy's alone among the London hospitals a weight of opinion could be brought to persuade the London University authorities to ante-date their examinations by a few days. Failing that, it would surely be possible to arrange for a certain number of the previous housemen to remain at their posts for a week or ten days after the traditional date.

THE Hospital is unfortunate in losing the services of Mr. Eric Davies. After weathering the "blitz" at Guy's—not unscathed—he has been Superintendent at the Wilderness for the last eighteen months. He is to leave for Iran shortly, where he is to take a post with the Anglo-Iranian Oil Company. We join his numerous friends in wishing him every success.

Recent Advances

By NILS L. ECKHOFF, M.S., F.R.C.S.

GENTLEMEN,—It is commonly said that the text-books are ten years behind the times. If any one of us were to start writing a text-book to-day it would probably be several years before it would be ready for publication; by which time some of the earlier chapters might be a little out of date. Furthermore, the writer would probably avoid mentioning the most recent work, as some of it might later be found disappointing.

There is much that we have learnt in the last few years that you may not find in your favourite text-books, and I shall attempt to-day to put before you some of the things that appear to me to be important.

Cross Infection in Hospital.—The obstetricians since the days of Semmelweiss have studied cross infection and, as the occurrence of infection in the puerperium can be such a disaster, have naturally directed all their efforts towards its exclusion. We general surgeons have not taken the matter so seriously in the past, for cross infection did not appear to be a serious matter in our ordinary surgical work. The presence of many open wounds in one ward (burns are an excellent example) have brought this matter to the fore. The raw surface of a burn is an excellent culture medium—or, perhaps, it would be better to say that a culture medium is the laboratory equivalent of a raw surface. The bacteriologists have done an immense amount of excellent work—chiefly on the Streptococci—and are now able to type the Streptococci with such accuracy that they can show without question how a particular streptococcus is spread—up and down the ward and back again, and from side to side.

The Medical Research Council have produced an excellent memorandum (No. 6) on hospital infection of wounds. I have previously lectured on this subject and so has Dr. Knott (*Guy's Hospital Gazette*, Vol. XVI, No. 1415, and Vol. LIII, No. 1327). The first striking fact is that the patients are not alone to blame. The doctors, students, nurses, maids and visitors have to look at themselves first, or, rather, at their own noses and their throats. It is a remarkable fact that at any one moment some 15 to 25 per cent. of the attending personnel in a hospital have streptococci in their throats, whether they are aware of it or not. It is a crime for anyone to attend the sick with an acute respiratory infection, but even those who think themselves sound must wear masks whenever a wound is exposed. I am glad to see that this practice is becoming universal. Note that it is fatuous for the doctors and nurses to wear masks during the inspection of a wound if the patient carries on an animated conversation without one.

There are a great many less obvious causes of wound infection. The air of the ward, vigorously stirred up with dust from the floor at sweeping time (no dressings till the ward has been ventilated); the blankets and sheets (care bedmaking); plasters and plaster shears; hot-water bottles; all utensils; bags and books; instruments and hands. It is very difficult to sterilise the hands (in these relatively gloveless days the multiplicity of suggested methods emphasises the difficulty), but gloves must be worn whenever possible and a "no touch" technique studiously practised.

Infusions and Transfusions.—Infusions and transfusions are carried out with such success to-day that one is inclined to forget the possible hazards of the methods. It is a great tribute to the blood banks and the pathologists that reactions are relatively infrequent. It is but a few years ago that the journals were full of discussion on the subject of reactions. For example, saline has to be made with thrice-distilled water if all pyrogenic (fever-producing) substances are to be excluded. When all this care is taken in producing reaction-free fluids it is sacrilege to see people cutting down on veins without masks, without gloves and without proper towelling—a difficult thing to arrange in bed at the best. It is often necessary to keep an infusion going for days, and to run the risk of introducing organisms direct into the blood-stream is quite unwarranted. Dr. Simpson has described cases of air embolism from defects in infusion apparatus.

Remember also that if saline is being administered (in intestinal obstruction, etc.), one is actually introducing chemical substances into the blood-stream and that dosage must be carefully studied. If, for example, 5 pints of normal saline be introduced in twenty-four hours, far too much sodium chloride is being added to the circulation.

As a rough estimate 1/5 N saline is correct for long infusions, or one pint of normal saline to four of glucose. Examination of the urine with silver nitrate acts as a check. In normal urine a slight haze of silver chloride is produced. No precipitation indicates too little chloride; a heavy precipitate indicates too much chloride.

In transfusion great advances have been made. Landsteiner died a few weeks ago. His classification of blood groups is accepted as the international classification—groups AB, A, B and O. The organisation of the blood banks is so complete that there appears to be an unlimited supply of group O blood, which is used freely, often without question. You are inclined to forget the blood must be grouped carefully and should be cross-grouped before use. Reactions from unsuitable blood may kill the patient by clumping of cells and glomerular blocking.

Recently another factor, the Rh factor (also found in Rhesus monkeys) has been described. Eighty-five per cent. of bloods are Rh positive. Repeated transfusions of Rh positive blood into Rh negative individuals may produce marked hæmolysis of red cells.

When you think of the possible hazards of intravenous therapy you will pause before giving an infusion and say to yourself: "Is this really necessary?" Remember that people used to survive operations remarkably well before the intravenous age, and that fluid can still be supplied by the mouth, per rectum, intramuscularly and subcutaneously, and that the patient is the best judge of how much can be absorbed.

I do not propose to discuss the indications for infusion and transfusion, but there is no doubt of their value in obstruction, in burns, in hæmorrhage and in shock.

Shock.—Dr. Grant, at the end of a long paper on air-raid casualties, says that the term "shock" is so loosely used in practice that he prefers not to use this label for his cases. Blalock says that shock is an "all inclusive term which denotes a disturbance of the circulation characterised by a diminution in the venous return of blood to the heart—resulting from a decrease in the ratio of the volume of blood in circulation to the capacity of the vascular bed."

The real cause of shock is not known and the response to treatment is variable, but, in addition to the appearance of the patient, the most useful single guide in the present state of knowledge is the blood-pressure. As a rough guide a blood-pressure of 100 mm. with a fair pulse pressure is taken as reasonable. But blood-pressure readings alone may produce remarkably equivocal results.

Crush Syndrome.—Opinions differ as to whether toxins pour from the damaged limb to the general circulation or *vice versa*. Sufficient to say that the muscles in the damaged limb may undergo marked necrosis—due either to direct trauma or to strangulation from their swelling inside the deep fascia—and that myohæmoglobin has been identified in the urine. These patients die of renal failure and the blood urea rises to 300 to 400 mg. per 100 c.c. Treatment is directed towards promoting diuresis by giving enormous doses of potassium citrate (up to grs. 360 per diem) and intravenous infusions of glucose or isotonic sodium sulphate.

The crushed limb becomes enormously swollen from œdema. Some have suggested intermittent compression as a therapeutic measure; others that the limb should be put on ice (*vide infra*) and only slowly thawed.

The Use of Silk, Floss Silk, Thread and Cotton.—Halstead, in America, was one of the greatest exponents on the use of silk. He was world-renowned for his gentleness, delicacy and accurate surgery. Silk has always been used by a minority of surgeons, but was in danger of being overshadowed by catgut. Non-absorbable sutures have come to the fore again in latter years, partly owing to their plentiful supply and cheapness and partly owing to their greater tensile strength and ease of handling. The most important and surprising fact is that there is *less* reaction around a piece of non-absorbable material than around a piece of catgut, which makes for better and quicker healing. Some surgeons use no catgut in the abdominal wall, as they believe it favours dehiscence. A note of warning: If infection occurs when using silk, the patient will not thank the surgeon, for silk sutures will be extruded for months or years before healing is final. Therefore when preparing or handling silk the "no touch" technique must be employed wherever possible.

Chemo-therapy.—I have not much to add to what you already know on this subject. Its value in the treatment of streptococcal infections is accepted; there are a few resistant strains. All the sulphonamides appear to be effective, but remember that sulphanilamide is the cheapest, sulphapyridine tends to produce sickness, which one

writer claims to control by dividing the four-hourly dose into eight half-hourly doses, giving the crushed tablet in milk with a pinch of sod. bicarb. and finishing at 10 p.m. with 1 gm. intramuscularly, omitting further dosage till 6 a.m. Sulphathiazole has been difficult to get—it is now on the market again—and, although it was hoped that it would help in staphylococcal infections, I think it is fair to say that the results are disappointing. Sulphadiazine is well spoken of in America, but has been difficult to get here. Sulphaguandine is used in intestinal infections with good results.

The first experiences with propamidine (a diamidine compound produced by May & Baker) have been promising. But the most startling evidence surrounds penicillin (derived from a mould called *Penicillium notatum*) for all sorts of infections, including extreme staphylococcal septicæmia, pneumococci and sulphonamide resistant streptococci. This drug is, unfortunately, in extremely short supply, for it cannot yet be produced on a sufficiently large scale to be available to more than a few special centres.

Gas Gangrene.—A recent publication of the Medical Research Council stresses the fact that many different bacteria may be found in clinical gas gangrene and that in the North African campaign there was a high proportion of Cl. œdematiens. Prophylactic injection (9,000 units Cl. Welchii antitoxin, 4,500 Cl. Septique, and 3,000 Cl. œdematiens) is recommended in all wounds where much muscle laceration is present and very careful removal of all damaged tissue; therapeutic injection is three times the prophylactic. Sulphonamides are recommended in addition.

Gangrene, Frostbite, Immersion Foot.—Frostbite is nowadays a malady of air crews in high flying, and a very short exposure to substratosphere temperatures is sufficient to do much harm.

Immersion foot is seen in the case of seafarers and airmen who have spent days in open boats or dinghies. Œdema is followed by gangrene.

In both conditions it is now established that rapid heating is the worst treatment. Friction is positively contra-indicated (whether with warm or cold hands) and actual cooling with very low return to normal temperatures is the right treatment. An ice-box has been designed by Raymond Greene to achieve this.

We apply this knowledge to the treatment of dry gangrene. A gangrenous part should not be warmed, for this raises the metabolism beyond the point which the arteries will permit. On the contrary, it should be kept outside the bedclothes at low room temperature.

Ice is actually used in gangrenous limbs requiring amputation. A tourniquet is placed around the limb and the limb placed on ice for two to three hours. Amputation can then be carried out without anæsthesia and without shock. Freezing checks pain, hæmorrhage, infection and tissue devitalisation.

Note that freezing is a method of producing shock in experimental animals. Freezing followed by thawing produces a plasma shift which leads to severe and fatal shock within six to twelve hours. For this reason it is a little early to foretell the value of freezing as a therapeutic measure.

Blast Injuries.—A recent air-raid experience reminds me of the importance of blast injuries, so well described by Gill and others. We had several instances of hæmothorax without external wounds, one associated with rupture of the colon. I mention it merely to remind you of the possibility in accidents of this type.

The Courage of Our Convictions

A CASE OF HYSTERICAL VOMITING OF PREGNANCY

By D. W. JAMES.

"IT can be instantaneously stopped by the simplest form of psychotherapy." Obstetricians will, no doubt, be grateful to Sir Arthur Hurst for solving so easily in his recent article, the problem of hyperemesis. But while admitting that Sir Arthur " has something " which we do not possess, I would venture to suggest that something more than courage and personality is sometimes necessary to cure these cases. The following case, which actually happened some years ago, is reported to show that for some of us the course of true psychotherapy does not always run smoothly.

The scene is the general ward of a hospital. The patient is ten weeks pregnant and has been admitted for hyperemesis. There are no signs of organic disease and she is to be treated as a case of hysterical vomiting. The other patients are all ears, for the patient is being very sick, and they sense that a battle is about to take place. I enter with the Sister of the ward and the following conversation takes place :—

Sister : " Her doctor said it was all nerves, but she seems very ill. Do you think we shall have to——"

Myself (sharply) : " Do not think of such things. It is never necessary to terminate these cases. They are all hysterical and can be instantaneously stopped by the simplest form of psychotherapy. You haven't given her a bowl, of course ? "

Sister (wearily) : " No, of course not, but the sheets . . . I have only three clean pairs left."

Myself (confidently approaching the patient, in full view of the ward) : " Now, Mrs. Jones, you are going to have a really good meal. There is really nothing wrong with your stomach, you know ; it has just got into a bad habit. Of course, you do want to have this baby ? "

Patient (retching slightly) : " Oh, yes, Doctor, of course I do. But why do I feel so sick ? "

Myself (aside to Sister) : " You see ? She obviously does want it, but this is evidence of a psychological conflict. A distorted attempt of the unconscious mind to get rid of the embryo, and, of course, quite compatible with her desire to have a child." (To the patient.) " Was your mother sick when she was carrying you ? Ah, I thought so ! And your husband, is he feeling sick now ? " (Aside to Sister.) "They often do, you know, and that is further evidence of the psychological nature of the disturbance." (The patient does a good vomit and we back away from the bed.)

Myself (sternly) : " Now, Mrs, Jones, you are not going to be sick any more." (Her diaphragm heaves ominously.) " Take a deep breath through your nose and tell me what you would most like to eat ? " (After a great deal of deliberation she decides upon tomato sandwiches.)

Patient : " But I know I shall be sick if I have them."

Myself : " Oh, no ! You couldn't have chosen anything better. They are absolutely certain to stay down. You expect to be sick merely because your mother was sick. You realise, of course, that we shall do nothing to get rid of this pregnancy for you ? " (More gently.) " Well, now that you understand why you are feeling sick you will have no more trouble. Ah ! Here are the tomato sandwiches."

I hand her one, explaining and persuading gently all the time. She takes a mouthful and promptly vomits it. With a sigh I remove a piece of tomato skin from my coat and turn to resume the battle. But she looks queer somehow. She starts to twitch. Her eyes roll up and slowly she passes into a major fit. The whole bed shakes and Sister rushes for screens and oxygen. She is very blue. She is very grey (and so am I). Safely out of sight behind the screens we artificially respire her. Slowly she comes round, but she does not look well at all.

Myself (rather quietly to Sister) : " Of course, that was an hysterical fit." (Very quietly indeed.) " I think you had better get the theatre ready."

Slipping dejectedly out of the ward I decide that I must buy myself a monocle, but first I must go and look out a nice blunt curette.

Correspondence

BORROWING PERIODICALS.

To the Editor of the GAZETTE.

SIR,—I should like to draw attention to the pernicious practice of " borrowing " periodicals from the reading-room of the Wills Library. These have been provided for the use and help of everybody and should not be taken away. This rule has not recently been observed as strictly as it might be. It should be unnecessary to put up reminders in the form of unpleasant notices to suggest that this will not recur in the future. Students may be students, but they should not forget that there are others besides themselves.

Yours, etc.,

Guy's Hospital, S.E.1. I. T. THE.

ROYAL MEDICAL BENEVOLENT FUND.

To the Editor of the GAZETTE.

SIR,—It is my custom each autumn, through your columns, to invite my medical colleagues to take their part in the Christmas Gifts Fund of the Royal Medical Benevolent Fund.

This scheme so generously supported by many has become very remarkable, as it has been the means not only of bringing to many old and lonely people a gift of friendship and sympathetic understanding at Christmas-time, but it has also given many of your readers an insight into the great work which the Royal Medical Benevolent Fund is doing daily in helping medical brethren, or the widows and children of deceased medical practitioners who are in financial difficulties.

We look upon the Christmas gift of £2 to each beneficiary as something "extra," but I must emphasise that the regular allowances have to be paid throughout the year. New annual subscribers are very urgently needed for our general funds, and surely it is for the present generation of practitioners to take up their share in a work which is a common professional inheritance and tradition.

It is not difficult to realise what happiness and comfort a Christmas gift of £2 brings to an old doctor, an aged widow or daughter living alone, possibly suffering from illness or infirmity. We ourselves know the difficulties and discomforts of our own lives caused by the present War. May I appeal, Sir, very earnestly on behalf of those who have suffered so much more than ourselves!

I venture to make this letter a *two-fold* appeal—

(*a*) to all regular subscribers, to send their "extra" for the Christmas Gifts fund.

(*b*) to all others, to show their practical sympathy by becoming subscribers to our general funds.

I do not ask for large contributions.

Christmas Gifts donations should be marked "Christmas Gifts," and all cheques made payable to the Hon. Treasurer, Royal Medical Benevolent Fund, 1, Balliol House, Manor Fields, Putney, S.W.15.

I am, etc.,

THOS BARLOW, President.

USE OF LIBRARY.

To the Editor of the GAZETTE.

SIR,—Since the War began organised teaching has had to be considerably curtailed, and reading has become more important than ever. For this reason we feel that facilities for reading in the Wills Library might well be extended. We therefore make the following suggestions :—

1. That there should be open access to all the books. A library is not truly fulfilling its function unless readers can browse freely among all but the most precious of its books.

2. That the library should be open until 7 p.m. at least. It is clearly not fair to ask the librarian to work after 5.30 p.m., but even if the books themselves were shut up when he left and the library used as a reading-room in the evening, the gain would still be considerable. Alternatively a system might be tried which works in certain American universities where students themselves act as librarians in the evenings and libraries are open until 10 p.m.

We believe that these changes might be instituted now, and that they would be a great help to all students.

Yours, etc.,

A. BATTY-SHAW, S. M. HILTON,
J. E. BLUNDELL, R. E. IRVINE,
C. H. KINDER, J. D. L. REINHOLD,
H. W. TRUSTED, M. G. THORNE.

Reviews

The Essentials of Modern Surgery. Edited by R. M. HANDFIELD-JONES and A. E. PORRITT. Second Edition. Published by E. & S. Livingstone, Edinburgh. *Price 40s. net.*

THE call for a second edition of this text-book during war-time is an index of its popularity, and one can say without hesitation that the complete revision to which it has been subjected will enhance its reputation still further. An immense amount of work has been expended on bringing the book up to date, many improvements have been effected in the subject-matter and many new illustrations have been added. The publishers have succeeded, in spite of restrictions, in maintaining their irreproachable standard; it would be impossible to imagine a book of better appearance.

In the light of increased experience the chapters on Wounds, Burns, Hæmorrhage and Shock have been rewritten and considerably expanded. Those on Inflammation and Infection, Cleft Palate, the Thyroid Gland and Hernia have also been rewritten and re-arranged. These alterations are universally approved, and so far as the student is concerned the chapter on Hernia has attained much greater clarity. The three chapters on the subject of Fractures have been entirely revised; and that on Deformities has been rearranged, with the addition of a section on Low Back Pain.

The contributors to the book are all well known and the standard of the individual articles is high. With his colleague on active service the remaining editor is to be congratulated on producing so fine a book under tremendous difficulties. As a standard text-book of general surgery it can be recommended wholeheartedly to serve all student purposes.

S. H. W.

Notes for the R.M.O. of an Infantry Unit. By C. P. BLACKER. Oxford War Manuals. *Price 5s.*

THE newly-qualified house officer discovers for the first time the importance of administration in medicine, although in a hospital most of it is carried out by others. The R.M.O. is less fortunate, and Dr. Blacker deals largely with just those points of organisation, record-keeping and training of personnel which will enable the former to avoid many mistakes from the outset. In addition, some medical problems of special importance to the Army are discussed—malingering, venereal disease, neurosis, the use of morphia. The last but not the least important section discusses the great opportunities open to the R.M.O. of promoting the physical and mental well-being of the men under his care. A booklet devoted mainly to administration might be excused for being dull, but Dr. Blacker successfully avoids this by means of frequent allusions to his own experiences.

P. L. M.

A Synopsis of Surgical Anatomy. By A. LEE MCGREGOR, F.R.C.S. Fifth Edition. Published by John Wright & Sons, Ltd., Bristol. *Price 25s. net.*

TWO reprints of the last and this new edition have been produced since the War began. Several new sections have been added and some chapters entirely rewritten. It is a source of surgical and anatomical information of compact, but readily accessible form. The line drawings are simplicity itself and exactly illustrate what they are intended to show. An excellent short book of reference.

E. R. D.

Sport

Rugby

GUY'S *v.* MIDDLESEX HOSPITAL.

(At H.O.P. on October 2nd)

Against the stiffer opposition Guy's were less impressive than last week. The whole side lacked life, but later the pack improved and did much to prevent Middlesex from scoring. Of the backs Strathie showed occasional flashes of brilliance, and Graham sustained the promise he had already shown. Hildick-Smith at full back was spectacular and efficient, but a little slow.

The first half was even though Middlesex pressed hard all the time, and Guy's were lucky to get the only score. This was a try by Brittain after a forward rush.

After half-time Strathie cleverly broke through and nearly scored, but just failed to get over the line. A scrum was given and after a quick heel the ball went out to Hildick-Smith, whose weight and speed carried him over the line. Then N. K. Macrae-Gibson ran three-quarters the length of the field to score from a dropped pass. This made the game safe, though Middlesex continued to press and were unlucky not to score.

Score: Guy's, 1 goal, 2 tries, 11 points; Middlesex, nil.

Team.—G. Hildick-Smith; J. N. Micklem, D. M. Strathie, N. K. Macrae-Gibson, A. C. Macrae-Gibson; E. W. Graham, R. N. H. Vann; A. Batty Shaw, A. B. Lee (captain), R. G. L. Brittain, D. L. Gullick, C. Ziervogel, P. D. Harvey, C. Vidot, P. C. S. Campion.

Hospital Information, etc.

Notices

RUGBY MATCH

A centenary match will be played on Rugby School Close on Saturday, December 4th, between the Hospital XV and Rugby School Past and Present.

It is proposed that after the match a war-time dinner will be held in Rugby, at which all old Guy's men will be welcome.

Anybody wishing to attend should get in touch with Dr. R. E. Smith, M.D., F.R.C.P., The Sanatorium, Rugby School, who will give them all particulars.

CENTENARY YEAR RUGGER DANCE

A dance to celebrate the hundredth year of the Guy's Rugger Club has been arranged, and will take place at Grosvenor House, Park Lane, on Tuesday, November 30th.

Dancing will be from 9 p.m. to 1 a.m., and an extended licence for the bar has been obtained.

Double tickets at £1 1s. and single tickets at 12s. 6d. may shortly be obtained in the Hospital.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

PRE-MEDICAL AND PRIMARY EXAMINATIONS.

October, 1943.

Anatomy.

D. M. H. Bickmore J. L. Hardman
J. Bunyan

Physiology.

D. M. H. Bickmore C. J. Johnston
C. D. Bulstrode P. Read
A. L. Jeanes J. Southgate

Guy's Hospital Medical School

October, 1943.

The following awards have been made :—

Open Junior Science Scholarship.
B. J. Silkoff.

Confined Junior Science Scholarship.
J. E. H. Lahaise.

Edgcumbe Prize for Junior Science.
C. J. Earl.

Open Arts Scholarship.
R. Handy.

The Michael Harris Prize for Anatomy.
J. C. Crook.

Embryology Prize.
J. C. Crook .. } Bracketed
I. A. H. Munro .. } equal.

The Wooldridge Memorial Prize in Physiology.
J. Luder.

Epsom Scholarship.
A. A. Craigen.

University Entrance Scholarship.
A. G. Parks .. Scholarship.
G. A. K. Missen .. Exhibition.

The Beaney Prize for Pathology.
R. R. Burn.

Change of Address

F. W. Gilbert, M.D., Ndola, N. Rhodesia.

W. A. Porter, Ft.-Officer, R.A.F., 61 Mobile Field Hospital, R.A.F., Indian Command.

G. Thurston, Lieut.-Col., R.A.M.C., 17 British General Hospital, Indian Command.

G. W. Downs, Lieut., R.A.M.C., 104 General Hospital, B.N.A.F.

F. S. Warner, M.R.C.S., L.D.S., 88, Harley Street, W.1.

Papers by Guy's Men

Denny-Brown, D. The Principles of Treatment of Closed Head Injury. *Bull. New York Acad. Med.*, 1943, v. 3.

Hallpike, C. S., and Another. Some recent work on the investigation and Treatment of "Menière's Disease. *Proc. Roy. Soc., Med.*, 1943, **36**, 533. (Sect. Otol.)

Brock, R. C. Surgical Treatment of Bronchial Carcinoma. *Brit. Med. J.*, 1943, ii, 257.

Rogerson, C. H. Psychology in General Practice. IX. Visceral Neurosis. *Practitioner*, 1943, **151**, 178.

Rowlett, A. E. A Philosophical Approach to Dental Education. *Brit. Dent. J.*, 1943, **75**, 118.

Simpson, C. Keith. Mass Asphyxia : Medical Aspects of the Tube Shelter Disaster. *Lancet*, 1943, ii, 309.

Douthwaite, A. H. Achalasia of the Cardia : Treatment with Nitrites. *Lancet*, 1943, ii, 353.

Saner, F. D. Treatment of open fractures. *Post. Grad. Med. J.*, 1943, 19, 187.

Bradlaw, R. V. Diagnosis of Diseases of the Gums. *Brit. Dent. J.*, 1943, **75**, 147.

Shuttleworth, C. W. T. Bacteriology in Diagnosis. *Brit. Dent. J.*, 1943, **75**, 150.

Fry, W. Kelsey. The Baptist Church Cellar Case. *Ibid.*, 154.

Awards

M.C.

Captain L. Babrow, S.A.M.C.

Births

DAVIS.—On September 29th, at Maidstone, to Peggy (née Parks), wife of Flight-Lieut. E. I. Davis (overseas)—a daughter.

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVII. No. 1443 *13th November, 1943* *Ninepence*

PASSIM

IN a few days' time—on Saturday, November 27th, to be precise—the Rugby Club will commemorate their hundredth season with a match against the London Rugby Union.

Of late a wave of curiosity has swept the country. We have had our Brains' Trusts, national and local, culminating in questionnaires on the lesser known French dramatists. All have the double appeal that, even if one does not wish to acquire knowledge, one has adequate excuse for exhibiting the same. This leads us to speculate on the depth of what can be called "general knowledge of Guy's" at Guy's. Personally we are ashamed, but are conceited enough to imagine that our ignorance is not unique. At first sight it may seem valueless to know that one of the greatest financial frauds in history—to wit, the South Sea Bubble—made the formation of Guy's possible; that the *Gazette* was first printed in 1872; that the Physical Society was founded in 1771 and is probably the oldest medical society in London. Agreed that each or all of these facts is, or are, of themselves unimportant, yet they form a pointer by which to gauge a trend of interest which is of great moment to the Hospital. In fact, we return to that horribly-maligned and much-misused word "Tradition." It is inevitable that the present generation at Guy's should miss much of that steeping which has raised the Hospital in the eyes of former students to a height almost supernatural; to form a guiding principle and ideal after they have left. Shall we lightly pass over anything which may help them to assimilate a modicum of this influence and which may serve to eradicate that phrase so often heard at the Bases, "Guy's is only a name to me"? We apologise for being so un-English as to verge on the sentimental, but tradition is itself a sentiment. As we have remarked, in a fortnight's time Guy's are to commemorate the hundredth anniversary of the foundation of their Rugby Club. It is an occasion on which all and sundry, whether they are students isolated at the Base Hospitals, or have already qualified, can realise that they are not merely doing their medicine or their dentistry, but are doing so at *Guy's*.

This is not the place to delve into the evidence for supposing the date of the inauguration of the Rugby Club to have been 1843 (making it to be the oldest club in existence with the exception of Rugby School), nor to enter into a *resumé* of its subsequent progress; a programme will be on sale at the match giving all this. More immediately let us recommend reference to Mr. Allport's article in the bicentenary issue of the *Gazette* (1925). That our claim is officially recognised is shown by the pains others have taken to ensure that the event does not pass unnoticed and to whom we extend sincere thanks. Most pertinent is the acceptance by the London Rugby Union of this special fixture with us. St. Mary's Hospital have kindly invited our team to a dance after the "away" fixture on November 13th. Rugby School are to entertain the 1st XV to dinner after a game on the Close on December 4th. For ourselves suggestions which were recorded in 1938 have had to be passed over. There can be no tour of the Provinces, no large gathering of Guy's players at an appropriate dinner; the publication of a complete history of the Club now in the hands of the Librarian has had to be postponed. Instead, a number of invitations have been issued to representatives of the Rugby Union, other clubs and to former celebrated Guy's players to a meal at Honor Oak Park after the centenary game. A dance has been arranged for the following Tuesday at Grosvenor House.

Finally, we ourselves tender our congratulations to the Club and wish them every success in future years, but most especially to Alan Lee and his team for the remainder of this season.

WE record with pride the award of the D.S.O. to Acting Wing Commander Raymond Hiley Harries, who was a dental student at Guy's in 1934-35. He had already received the D.F.C. and two bars.

Acute Peritonitis

A Clinical Lecture by E. G. Slesinger, O.B.E., M.S.

GENTLEMEN,—I have taken acute peritonitis for my lecture to-day, as I thought it might be helpful to bring together information on a subject which is often rather scattered in your text-books.

Acute peritonitis is, as you know, a very grave condition, mainly because both the area and the powers of absorption of the peritoneum are large. On the other hand, its powers of resistance, too, are large, particularly that of the pelvic peritoneum. This power of resistance varies phylogenetically, the horned animals having a much greater resistance than the hoofed ones, no doubt as the result of their methods of fighting.

The sources of infection are from without, from the blood-stream and from the contained viscera, of which the latter is by far the commonest. Infection from without may follow wounds or injuries, though these are often associated with visceral injury as well, and it certainly accounts for many cases of gonococcal peritonitis, infection ascending *via* the fallopian tube. Occasionally, too, peritonitis may follow a technically faulty laparotomy.

Infection from the blood-stream is equally infrequent. Some cases of pneumococcal peritonitis are undoubtedly blood-borne, and a proportion of gonococcal infections probably are as well. Both streptococcic and staphylococcic septicæmia may show a terminal peritonitis, but these occur, as a rule, too late in the disease to be recognised during life. Occasional cases of primary streptococcic peritonitis do occur, but they are rare; and it is doubtful if they are really blood-borne infections.

By far the commonest cause is infection from the contained viscera, and of these the great majority arise directly or indirectly from the passage of organisms through the wall of the alimentary canal. This may be due to an actual rupture of the wall, but is far more often the result of inflammatory, vascular or mechanical changes which permit the passage of organisms through its intact walls. The most frequent single cause of acute peritonitis is appendicitis. When the appendix is inflamed, bacteria escape through its walls and lead, usually, to a local adhesive or a local suppurative peritonitis. If, however, the patient's resistance is poor, or if the appendicitis is obstructive leading to early gangrene or perforation, a local reaction has not time to occur, and acute spreading or diffuse peritonitis results. This is commoner in children than in adults and in first than in subsequent attacks, and not infrequently results from a well-meant but misguided dose of castor-oil.

Even with a good local reaction rough handling during examination or badly planned surgical intervention may separate adhesions, which are often but filmy, and lead to spreading infection.

Both diverticulitis and acute cholecystitis sometimes cause acute peritonitis, but usually they result in local adhesive change or abscess formation. Examples of peritoneal infection produced by migration of organisms through an intact bowel wall are seen in the peritonitis occasionally met with in typhoid fever without perforation, or in pneumococcal peritonitis secondary to pneumococcal enteritis.

In intestinal obstruction and strangulated hernia, again, vascular and mechanical changes speedily permit the passage of organisms through the bowel wall, but in all these types of transudative peritonitis the infection is a gradual one and the reactive forces of the peritoneum have time to respond, so that the resultant peritonitis is adhesive in type, with or without abscess formation or more widespread with little pockets of pus between adherent coils of bowel and omentum.

Perforation of a hollow viscus, however, by reason of the suddenness with which the disaster occurs is responsible for the most virulent and generalised type of acute peritonitis, and the lower the perforation is in the length of the bowel the more virulent will be the resulting peritonitis. In perforative peritonitis the appendix, again, is the commonest cause—a fact, I think, sometimes not fully appreciated. Obstruction of the appendix with gangrene, or a perforating ulcer of the appendix, leads to a sudden peritoneal flooding with no time for any protective adhesion formation to occur. After the appendix, peptic ulcers of stomach or duodenum are the next commonest site for perforation, and less common sites are areas of diverticulitis of the colon, ileal ulcers,

especially the typhoid ulcer, and leakage at the site of a surgical anastomosis. Rupture of the gall bladder and perforating wounds of any hollow organ are other causes of sudden peritoneal flooding.

Apart from the gastro-intestinal tract, the uterus is the most important organ from which spread of infection may result in acute peritonitis. The spread of infection may occur directly through the fallopian tube, but probably occurs more often by way of the lymphatic channels. In the new born infant it is well to remember that infection of the thrombosed umbilical vein is an occasional cause of peritonitis by direct spread. One important fact I should like to impress on you is this, that whereas peritonitis not infrequently gives rise to infections of the thoracic cavity by spread, the reverse process is exceedingly rare and infections of the lung and pleura practically never result in a peritonitis.

TYPES AND SYMPTOMS.

As peritonitis is almost invariably a secondary infection its symptoms are usually mixed with and often confused by those of the primary lesion, and, again, the picture it presents varies greatly both with the type of peritonitis present and with the nature and virulence of the causative organism. If we consider the symptoms as they depend upon the extent of infection, we can recognise three groups—namely, local, spreading and generalised peritonitis; while when we take into account the causative organism it will be seen that infections by the pneumococcus, the gonococcus and the streptococcus each present a particular symptom complex. Local peritonitis comprises those cases where the infection has not spread beyond the primary point of infection or is limited to a strictly local area. A slow infection and a high degree of peritoneal reaction determine this type of case. Exudates glue neighbouring surfaces to the infected organ and to each other and, within twelve hours or so, a barrier is formed sufficient to wall in the infection, but yet so filmy that the lightest ill-advised touch of the surgeon's finger during operation will separate it and allow infection to spread. Such a local peritonitis may progress in any of three ways:—Firstly, it may subside, taking about a week to do so; secondly, an abscess may form within the boundary of the limiting adhesions; and, thirdly, the adhesions may fail to arrest the infection, or an abscess which has formed may spread through them, resulting in the case passing into the second group—that is to say, spreading peritonitis. Local peritonitis is usually the sequel to infections of such organs as the appendix or gall bladder, and its symptoms are not easily separated from those of the originating disease. Pain, widely distributed at first, but becoming localised, continuous rather than colicky in character, is usually present. It is accompanied by muscular rigidity. It is important to remember that muscular rigidity invariably connotes inflammation of a serous surface, and in local peritonitis it is widespread at first, like the pain, but soon becomes local, and, indeed, this narrowing of the pain and rigidity into a local area is reliable evidence that the peritonitis is of the local type. Tenderness is present and so is a moderate degree of pyrexia, and another important point is the presence of a polymorphonuclear leucocytosis. If the temperature and leucocytosis increase at the same time as the area of tenderness and rigidity diminishes, it is good evidence of abscess formation within the walled-off area.

Spreading peritonitis is the result of a battle between the invading bacteria and the resisting forces of the peritoneum in which the former are too strong or the latter too weak to permit of a stabilisation of the infected area by adhesions. It often accompanies appendicitis and frequently follows in cases of intestinal obstruction unrelieved for many hours. Peritoneal reaction is often intense and coils of gut become glued together with sticky exudate, while, later, pockets of pus form between them. Pain, at first local, spreads with the infection, until it may cover the whole abdomen. It is often severe and may be definitely colicky in nature. The abdominal signs are tenderness, rigidity and moderate distention. On auscultation peristaltic sounds of decreased frequency and loudness may be heard, or there may be complete silence. Constipation is of varying degree and, unless the peritonitis is the sequel of mechanical or dynamic obstruction, an enema will give a result. Such a case, if left alone, may progress for weeks. The patient becomes profoundly septic, with dry furred tongue, rapid pulse and a hectic temperature. Rigors and sweats occur, and a rising leucocytosis is usually found. It is such cases which often terminate in a fatal septicæmia or suppurative pylephlebitis. Empyæma not infrequently occurs, and in the lucky case there may be an abdominal abscess which bursts and drains into the bowel.

Generalised peritonitis follows the perforation of a hollow organ or the sudden rupture of an abscess into the general peritoneal cavity. It represents a sudden flooding of the peritoneum with no time for any preliminary reaction on its part. When a reaction does take place it is general and quite unable to wall in infection as in the previous type of case I described. The patient, who may have been quite well, is seized with acute abdominal pain often associated with the sensation of something having given way, and with an inability to draw a deep breath. The pain may be localised for a short time, sometimes providing a useful diagnostic clue, but rapidly becomes generalised and is often associated with a feeling of faintness or collapse and with pain in the region of the left scapula. In a matter of minutes the patient is cold and pale, his features are pinched and portray intense anxiety. Beads of sweat stand out on his skin and his pulse is barely perceptible. He complains of nausea, though he seldom vomits, and he is thirsty but terrified to drink. In a quarter to half an hour a certain improvement takes place. The pain, though severe, is not such agony, and may become colicky in nature, and the pulse, though rapid, improves in volume. The abdomen, from the first, shows a board-like rigidity. It is tender to the slightest pressure and is often retracted, though occasionally slightly distended. Liver dulness is absent, but I should like to stress that this sign is of no value unless a previous examination had shown normal dulness present. This picture represents the shock of sudden peritoneal flooding, and is gradually followed by the stage of absorption and reaction.

The patient becomes extremely restless, a characteristic and distressing sign in most forms of peritonitis, and the marked fluid loss and consequent shrinkage of the subcutaneous tissues gives rise to the well-known "facies Hippocratica" with its sunken temples, pointed nose and increased naso-buccal sulcus. The tongue becomes dry and the teeth covered with sordes; the pulse increases in rate, becomes thready and later running in character, and the temperature, which may have been subnormal, begins to rise. The abdomen is immobile, rigid and tender, and vomiting begins. The vomiting is frequent and of small quantity and, while it quickly becomes foul, it is seldom fæculent. Absolute constipation is present and distension increases in proportion to the state of paralysis of the bowel. On auscultation there is silence and, on percussion, an increasingly tympanitic note. Urine is scanty and concentrated and its passage often induces paroxysms of pain. Pain, indeed, is an outstanding symptom throughout the course of a generalised peritonitis. It passes through the stages of being generalised at first, then becoming colicky and again becoming general as the peritonitis develops. Pain is increased by the slightest movement, but, in spite of this, the patient cannot lie still and, since consciousness remains unimpaired, this picture of pain and restlessness, vomiting and thirst is one of unforgetable misery. Gradually the pulse becomes uncountable, the eyes become sunken, the extremities grow cold and the features become pinched. Restlessness, increasing voicelessness, together with the terribly unimpaired consciousness, make the end welcome, even though the pain usually lessens somewhat with approaching death.

Pneumococcal peritonitis often presents features which enable the nature of the infection to be diagnosed from the clinical picture alone. It is commoner in children than in adults and in girls than in boys. It occurs in two forms—the diffuse and the encysted—depending mainly on the resisting powers of the patient. In some cases it reaches the peritoneum from a pneumococcal enteritis or by way of the fallopian tubes from the vagina, but, in the majority of cases, it represents a part of a general pneumococcal septicæmia. The primary source may be a pneumococcal arthritis, otitis, pneumonia or empyæmia, and it is probable that in all these the infection is blood-borne to the peritoneum. The onset of the peritonitis is usually sudden, often accompanied by a rigor or a high temperature. The cheeks are flushed, the respiration raised and the accessory muscles of respiration are active, even if no lung lesion is present Vomiting, tenderness and rigidity are as marked as in other forms of peritonitis, but instead of constipation there is usually profuse diarrhœa. This association, especially in a child, of the cardinal symptoms of peritonitis with a profuse diarrhœa is often diagnostic in itself. In the diffuse form, if neither operation nor specific therapy is undertaken, death usually occurs early, but, if it does not, it is said that a crisis resembling that of pneumonia may occur about the seventh day, but I have never seen it. The commoner encysted form is less severe, pus collecting in the lower abdomen below the transverse colon and the patient seeming to improve for a few days. Gradually, however, the diarrhœa changes to constipation, distention increases, and, if operation is not undertaken, the pus may discharge at the navel. The characteristic greenish and odourless pus in these patients enables one to make a confident diagnosis at operation or if the pus discharges.

Gonococcal peritonitis is rare, and becoming increasingly so. It does, however, occur occasionally both in a diffuse form and as a local pelvic infection. It is commoner in females than in males owing to the channel provided by the fallopian tubes, the male cases, when they occur, being secondary to vesiculitis. While the gonococcus initiates the peritonitis, the B.C.C. soon exudes from the bowel and overgrows it, so that it is often very difficult to find gonococci in cultures taken from the peritoneum. The symptoms, though similar to other types of peritonitis, are mild and the prognosis since the introduction of M.B. 693 is good, operation being seldom required.

Streptococcal peritonitis is almost always secondary to puerperal infections, although occasionally it follows alimentary lesions. It is commoner after first deliveries and is usually associated with retained products, and the peritonitis is usually of the spreading type. The striking feature is the rapid development of a septicæmic state. High temperature and rigors are common and diarrhœa is more usual than constipation. Rigidity is generally absent owing to the stretching of the abdominal muscles as a result of the pregnancy and consequently distention is often considerable and occurs rapidly. The lochia are offensive and milk secretion is often suppressed. This type of infection presents great dangers of spread to other patients and has, therefore, been made a notifiable disease. The introduction of the sulphonamides has helped greatly to reduce the mortality of this condition, but it remains one greatly to be dreaded and one only to be prevented by the most meticulous care in the conduct of delivery.

DIAGNOSIS.

The main difficulty in diagnosing peritonitis is in cases where the patient is too ill to react or where the severity of the causal condition masks the peritonitic symptoms. On the other hand, the diagnosis of the condition to which the peritonitis is secondary is often very difficult and sometimes impossible before operation.

The cardinal signs of peritonitis are the severe pain and tenderness, the rigid abdomen, the small thready pulse of rising rate, the restlessness, the vomiting, the constipation and the absence of peristaltic sounds on auscultation.

Any one or more of these signs, however, may be absent and a diagnosis must be based on the presence of some of them in combination. Peritonitis is most commonly mistaken for acute intestinal obstruction, and, of course, the two frequently co-exist. Before the onset of peritonitis, however, the obstruction case is distinguished by the absence of tenderness and rigidity, the colicky nature of the pain, and the presence of exaggerated peristaltic sounds. Lead colic, basal pneumonia, diaphragmatic pleurisy and gastric crises in tabes are conditions which can be eliminated by routine examination, but it is worth remembering that in the tabetic patient the sensory symptoms of a peritonitis may be so damped down that its presence is not infrequently overlooked.

TREATMENT.

The treatment of peritonitis varies with the type, but careful judgment is often needed in order to avoid doing harm rather than good. In local peritonitis treatment depends on whether the process is extending. If localisation is maintained, as evidenced by narrowing of the area of tenderness and rigidity it is wisest to wait, since operation may break down barriers and lead to spreading infection, but, on the other hand, any sign of spread of the infection should lead to immediate operation to check the process. The treatment of spreading or generalised peritonitis has as its objective three things :—Firstly, the removal or limitation of the process causing the peritonitis ; secondly, drainage ; and, thirdly, the employment of specific therapy directed against the causative organism. The first two of these are achieved by operation where such measures as the closure of a perforation, the removal of the appendix or some such procedure is undertaken, followed by drainage, and the third objective is partly secured by leaving sulphonamide in the peritoneum. The best one to use, as far as is known at present, is succinyl sulphathiazole, which acts by the slow liberation of sulphathiazole and of which up to 15 grams can be safely left in the peritoneum, preferably in the form of an emulsion. In addition, certain adjuvant measures are of great importance. Firstly, the adoption of the Fowler position. This directs infective material away fron the dangerous diaphragmatic region and towards the more resistant pelvic peritoneum, and, in addition, relieves the diaphragm from the pressure of distended intestine, so allowing more efficient expansion of the bases of the lung to occur. Secondly, the fluid loss and the loss of chloride by vomiting must be replaced by intravenous glucose saline, which, in addition, by preventing hæmoconcentration, serves to diminish absorption from the peritoneum. Thirdly, an indwelling Ryle's tube to which inter-

mittent or continuous suction is applied, keeps the stomach empty and prevents vomiting with much relief to the patient.

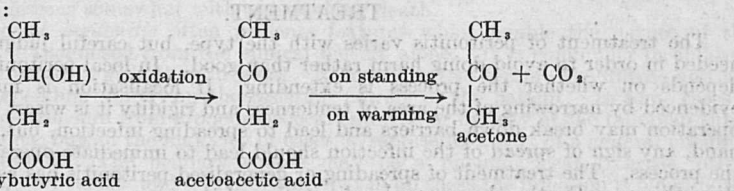
There is much argument about the right use of morphia in peritonitis. No one doubts that it should not be used until a diagnosis has been established and operation decided on, but there is still considerable controversy as to its use in treatment. The fears so often expressed that the use of morphine may encourage the development of inhibitive items are, in my opinion, nonsense, while it is of enormous value in combating shock, in checking restlessness, and by diminishing peristalsis—a very different matter to paralysing it—in preventing the spread of infection. When it is used it is best to use relatively small doses at spaced intervals rather than a single large one, but the dose must be ample to accomplish the purpose aimed at. If the patient is operated on a sulphonamide may, as I have said, be used locally, and, in addition, or if operation is not undertaken, it should be given systematically. Usually vomiting prevents oral administration, but a suitable preparation can be readily given in the intravenous drip without any additional discomfort to the patient. Even with every advantage that modern treatment gives, however, peritonitis remains a very grave disease, and it should never be forgotten that many cases could be prevented if more accurate diagnosis and prompter treatment were applied to the lesions which so commonly precede it. I think it is true to say that peritonitis is far less common than it used to be. That is to our credit, but complacency is even more dangerous in medicine than in war, and we must not rest content until better diagnosis and better treatment have relegated it to the realm of diseases of historic interest only.

Acetoacetic Acid

BY PROFESSOR CHARLES S. GIBSON, O.B.E., M.A., Sc.D., F.R.S.

IN his article (*Guy's Hospital Gazette*, vol. 57, 1943, 225) Sir Arthur Hurst refers on four occasions to the presence of *diacetic acid* in urine of patients exhibiting so-called pernicious vomiting of pregnancy. The use nowadays of this antiquated and, what is much worse, inaccurate name for acetoacetic acid seemed so surprising that I wondered whether many of those who have passed through our Chemistry and Physiology Departments during, say, the last forty years will be confused by the name which they may not have encountered in the Medical School unless it was when Sir Arthur Hurst was a demonstrator of physiology.

Sir Arthur Hurst is not the only one guilty of reversion to the use of this misleading name. Peters and Van Slyke (" Quantitative Clinical Chemistry," vol. II, 1932, chapter XVII) describe in detail methods for the determination in urine of the " acetone bodies." The relationships between these substances are correctly indicated by the authors, thus :



β-hydroxybutyric acid acetoacetic acid

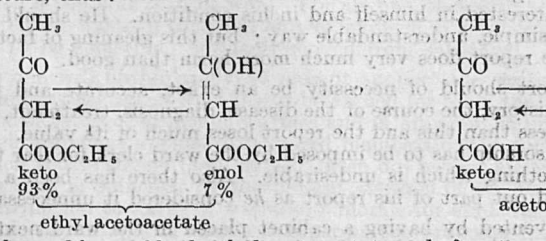
giving the usual name and constitutional formula for acetoacetic acid. Nevertheless, in the text, the authors in a few places describe acetoacetic acid as diacetic acid without any indication of what is meant by diacetic acid, to which there is no reference in the index. It is possible that other authors may be guilty of the same offence, but a search of those text-books of physiology which are immediately available (in Tunbridge Wells) and to which the names of former teachers at Guy's are attached has revealed that they are free from the error. The index of one well-known text-book (" Practical Physiological Chemistry," Cole, 1926) has the reference " diacetic acid, see acetoacetic acid," but in the text there is no mention of diacetic acid, leaving the reader in doubt as to what is meant by this name.

As indicated above, many methods for the determination of the " acetone bodies " in urine depend on the estimation of free acetone present as such together with the acetone produced from acetoacetic acid which, again, may be present as such and that formed by the oxidation of β-hydroxybutyric acid. If this last-named compound is present it is in the optically active (*laevo*-rotatory) form.

Acetone was known long before the era of what may be termed modern chemistry since, for example, it is one of the products of the distillation of wood in closed retorts. Consequently, the urinary odour of the breath and the acetone odour of the urine of patients exhibiting symptoms of what is now described as diabetes mellitus must have been a method of at least partial diagnosis of this condition. Such a method of diagnosis is all the more likely since at that period and even later many physicians were competent chemists and not a few contributed to the development of the science. Obviously, up to this time, the nature of the precursors of the acetone in the urine of the diabetic could not be determined until the chemical nature and properties of these substances had been investigated. For example, β-hydroxybutyric acid was prepared and its chemical nature and properties investigated in 1869 (Wislicenus). Its occurrence in diabetic urine was first demonstrated in 1875 (Kütz and Minskowski) and its presence in abnormal amount in diabetic blood in 1886 (Hugounenq).

The investigation of the constitution, properties and reactions of acetoacetic acid was more difficult owing to the instability of the substance. Our knowledge of acetoacetic acid dates from 1863 (Geuther) and 1869 (Wislicenus, Frankland and Duppa), and the ethyl ester (ethyl acetoacetate) was first prepared, starting from what we know was impure ethyl acetate. Owing to a misunderstanding of the constitution or, rather, of the properties of acetic acid and of ethyl acetate, ethyl acetoacetate when first prepared was described as ethyl diacetate. There is some interest in the fact that if chemically pure ethyl acetate had been used in the original experiments what was then wrongly described as ethyl diacetate would not have been obtained by the method of synthesis originally used. Having prepared the ethyl ester the original workers were able to obtain the corresponding unstable free acid, at the time obviously but wrongly designated diacetic acid. They investigated its properties and demonstrated the characteristic reaction of the ester and of the acid with ferric chloride. The presence of the acid in diabetic urine was demonstrated in 1875 (Geuther, Rupstein). It is now known to be present in very small amount in normal blood. The true chemical nature of the ethyl ester and of the acid was the object of investigations by many chemists and the name " diacetic acid " had to be abandoned since it was chemically erroneous. In the original literature the name diacetic acid (and ethyl diacetate) had, in fact, disappeared in 1869 in favour of acetoacetic acid (and ethyl acetoacetate), and these correct names were soon well established in chemistry (*see* Watts' " Dictionary of Chemistry," 1879). It is strange that the term diacetic acid persisted for a number of years in text-books of physiological chemistry, but, at the present time, there is no reason for using this wholly inaccurate name.

Ethyl acetoacetate (ethyl ester of acetoacetic acid) being much more stable than the free acid was for many years the subject of detailed and extensive investigations dealing with its physical properties and chemical reactions. It was shown to be an important intermediate in the preparation of antipyrine and other synthetic drugs. It still remains the classical example of the phenomenon known as tautomerism, desmotropism or dynamic isomerism (a term introduced by the late Professor T. M. Lowry when at Guy's). At the ordinary temperature pure ethyl acetoacetate is not a chemical individual but a mixture of what are known as the *keto* and *enol* forms, and the same is true of acetoacetic acid. These two forms are in equilibrium at the ordinary temperature, thus :



It is to the *enol* form of both ethyl acetoacetate and of acetoacetic acid that the reaction with ferric chloride (characteristic claret-red colour) leading to the identification of the ester and of the acid is due.

May one hope that *diacetic acid* will now disappear from literature emanating from Guy's ? If such a compound could exist and had the legitimate name of diacetic acid it would be of such an extraordinary nature that its occurrence in physiological fluids would be the despair of the medical profession.

Starlets Revue

DR. HILLS has just produced another of his successful revues. Starlet No. 4 was presented on October 28th and 29th in the old Pathology Theatre, and on both evenings a packed house enjoyed entertainment of high standard—entertainment which could only be described as uproarious for a great deal of the time.

The curtain rose with Sister Rowe preparing for a song. The familiar opening bars of the "Merry, Merry Pipes of Pan" caused some misgivings, but Sister Rowe delicately continued (singing "Pan" as opposed to the conventional yet inexplicable "Paan"), when—an embarrassing moment—she was barracked by a drunk from the back—embarrassing, until the identity of the drunk became obvious.

There was, indeed, no lack of variety. Messrs. Cutler and Ticehurst, assisted by Nurse Needham, gave a demonstration of their manly physiques. In the original and amusing sketches, the neurotic and idle rich bore the brunt of the wisecracks and more subtle "digs." The symptomatic discussion of three Bluffield House patients—a lady of indefinable complaints, a prostatic colonel and a youth of odd endocrine nature (played by Sister Rowe, Mr. Ticehurst and Mr. Merryweather) went down very well. Supercommercialisation of medicine (with manicure, hairdressing and liquor thrown in) as seen at the "Institute of Rationalised Medicine" was a welcome relief from the innumerable present-day discussions about State control.

The individual turns also showed a great deal of talent. Miss Hogg's song as the "Chairwoman of the Charladies' Union"; whilst Mr. Ticehurst collected the village salvage in West Country dialect. Mrs. Trethowan, accompanied by her husband, sang several charming songs. Mr. Cutler, as an Oriental gentleman of unfortunate title, gave a fascinating demonstration of black (?) magic.

Finally, the revue concluded with an "Operation in Opera" by the entire caste—a well-thought-out and cleverly performed act.

Altogether the producer and his cast are to be thanked for their energetic efforts and congratulated on an excellent and amusing performance. R. B.

Correspondence

PATIENTS AND CASE REPORTS.

To the Editor of the GAZETTE.

SIR,—I consider it is time that some measures were taken to prevent patients in this Hospital from having access to their own case reports. It is doubly harmful:—

Firstly, because they often see long medical names, which are frightening in themselves, and which they often look up in dictionaries afterwards; and they also can read the diagnosis and prognosis, which, in certain cases, is most undesirable. Any ill patient is naturally interested in himself and in his condition. He should be told all that is necessary in a simple, understandable way; but this gleaning of facts about his condition from a case report does very much more harm than good.

Secondly, a case report should of necessity be an exact, accurate and truthful account of the patient's history, the course of the disease, diagnosis, treatment, investigations, etc.; anything less than this and the report loses much of its value. Yet, in many cases, a sort of censorship has to be imposed by the ward clerk for fear that the patient should read something which is undesirable. Also there has been a case in which the patient crossed out part of his report as *he* considered it unnecessary.

All this could be prevented by having a cabinet placed in the ward next to the ward clerk's table. The cabinet could be fitted with shallow drawers, each clearly numbered and allotted to a bed. In these could be kept the case reports, X-rays and reports of investigations for each patient. It would involve no extra trouble—the temperature charts and bed letters remaining as at present—and would remedy a state of affairs which long ago should have been changed.

Yours, etc.,

Guy's Hospital, S.E.1. J. C. CROOK.

THE COURAGE OF OUR CONVICTIONS.

To the Editor of the GAZETTE.

SIR,—I am not sure how seriously Dr. D. W. James wishes us to take his story of a case of hysterical vomiting of pregnancy published in the *Gazette* of October 30th. He was such an excellent house physician and such a skilful psychotherapist that I cannot believe he would have made the serious mistakes recorded in his story. The explanation, persuasion and re-education which make up the simple form of psychotherapy I recommend are, of course, successive stages in treatment and cannot be practised simultaneously. The first interview with a woman suffering from hysterical vomiting of pregnancy must take place some time before a meal is due. A full history is obtained and an explanation of the symptoms is then given in language suited to the patient's intelligence. She is next told how she can overcome the bad habit. Not until she fully appreciates the argument and is herself convinced that she will be cured is there any certainty that the treatment will prove effective. It is much easier to cure hysterical vomiting away from a patient's home than when she is in the midst of her sympathetic and anxious family, and it is easier to cure her in a private room than in a general ward. If, however, no private room is available, the patient must be isolated by screens during the preliminary conversation and the first meal, and care should be taken that what is said is not overheard. Then it will be found that nothing more than confidence in the diagnosis and "courage in our convictions" are needed to cure the patient.

Yours, etc.,

Oxford. ARTHUR HURST.

RUGGER CENTENARY DANCE.

To the Editor of the GAZETTE.

SIR,—I wish to say that I am amazed at the advertisement in the current issue of the *Gazette* for a guinea Dance to be held at Grosvenor House to celebrate the centenary of the Rugger Club. I have no wish to discredit the Rugger Club in general or to minimise the importance of its centenary, but, unfortunately, affairs like this Dance are in danger of becoming accepted as legitimate and reasonable amongst Guy's students. No one who knows the students will expect them to be politically conscious, but the following elementary considerations should be obvious enough :—

(1) England is engaged in a war which threatens her whole existence as a nation in general and that of politically "free" students in particular.

(2) The majority of English men and women are undergoing great sacrifices, dangers and discomforts in order to fight this war, and have no time for expensive amusements of any sort.

(3) The present Government cannot by its nature completely control industry or economic life. (For example, it has failed to control the coal industry, or even to ration coal, because the interests concerned are opposed to Government policy.) It therefore relies on the good sense and patriotism of ordinary civilians to limit the expenditure of time and money on luxury goods and services, which must be drastically curtailed if the War is to be won. For anyone, therefore, to embark deliberately upon the extensive waste of time and money involved in a dance such as is proposed appears to me to be something not far removed from sabotage.

No one will unthinkingly at present support the strikers in the coal-mining and other industries, but at least it can be argued for them that their bitter attitude is the product of years of economic warfare and of apparent indifference to their well-being. No such argument applies to favoured members of the community, such as students, and such people should (and, indeed, often do) have a higher regard for their responsibilities than is indicated by the present attitude of the Rugger Club. Certainly it is no contribution to national warfare or morale for students to exploit and flaunt their economic advantages in such a manner as the proposed function might indicate. Of course, it is not suggested that all civilian pleasures should cease, and it would be disadvantageous to the War effort if this were the case. I am, however, increasingly disgusted at the amount of needless spending and luxury-seeking which are taking place. Anti-social persons of all kinds throng hotels, restaurants and night-clubs everywhere, while prodigious amounts of money and enormous quantities of time are spent in these places by people who have no need for such pursuits. However, two wrongs do not make a right, and supposedly educated students need not imitate the

more selfish of their elders in these matters, nor will they gain the respect and admiration of the saner sections of the community by so doing.

Yours, etc.,

5, Sandrock Road, Tunbridge Wells. G. HASLEWOOD.

THE LATE SIR WILLIAM ARBUTHNOT LANE.

To the Editor of the GAZETTE.

SIR,—An account of Sir William Arbuthnot Lane's life and work is to be written for the Guy's Hospital Reports, and it would be a great help if any of his house surgeons or associates could send material which might be of value, such as anecdotes, letters or photographs to me as Editor of the Reports. I will then arrange to pass them on to Mr. W. E. Tanner, who is going to write the account.

Yours, etc.,

R. C. BROCK.

NATIONAL WAR FORMULARY.

To the Editor of the GAZETTE.

SIR,—May I be permitted to add a few remarks to your excellent and, no doubt, timely editorial comments on the use of the N.W.F.

While its is obviously necessary both from examination and post-hospital aspects for the student to have some acquaintance with the N.W.F., one of the reasons why it is not so well known at Guy's may be that the Dispensary has consistently discouraged the prescribing of N.W.F. preparations.

This has been done because, after careful study, it was clear that the majority of G.H.P. formulas were as effective and definitely more economical than their counterparts of the N.W.F.

It was felt, and this view was expressed to the powers that be, that a greater contribution to the War effort could be made by continuing to use the G.H.P., modifying, where necessary, the formulas therein in compliance with Government regulations and M.R.C. recommendations as issued from time to time, than by scrapping the lot and adopting the N.W.F. in its entirety. The two should, in fact, be used side by side adapting the formulæ of our pharmacopœia to the recommendations of the official publication. The use of any other N.W.F. formula than those mentioned in the attached list is not justified from an economic point of view.

It is interesting to note that the 2,000 to 3,000 gallons of liquid paraffin used per year is now reduced to less than 200.

Yours, etc.,

J. MOORE,

Pharmaceutical Dept., Chief Pharmacist.
Guy's Hospital, S.E.1.

These *G.H.P. preparations* should be replaced by these *N.W.F. formulæ*:—

Glyc. Thymol Co. B.P.C.	Collut. Thymol Co.
Haustus Chloral	Haustus Chloral.
Haust. Chloral et Brom.	Haust. Chloral et Brom.
Haustus Filicis	Haustus Filicis.
Haust. Paraldehyde	Haust. Paraldehyde.
Linct. Diamporh. B.P.C.	Linct. Diamorph. Hydrochlor.
Linct. Scillæ Co.	Linct. Scillæ Opiatus.
Lotio Calamine	Lotio Calamine.
Lotio Rubra	Lotio Zinc Sulph.
Mist. Alba B.P.C.	Mist. Alba.
Mist. Bromid. Co.	Mist. Bromid. et Nux Vom.
Mist. Lobelia et Stramon. Co. B.P.C.	Mist. Stramon. et Iodid.
Mist. Opii Acid	Mist. Opii Acid.
Mist. Stramon. Co.	Mist. Stramon. et Iodid.
Mist. Valerian Co.	Mist. Bromid. et Valer.
Pulv. Acid Boric Co.	Pulv. Zinci Co.
Pulv. Acid Salicyl. Co.	Pulv. Zinc. Co. et Ac. Sal.
Pulv. Bism. Co. B.P.C.	Pulv. Mag. Trisil. Co.
Pulv. Zinc et Ac. Sal.	Pulv. Zinc. Co. et Ac. Sal.
Pulv. Zinc et Amyli	Pulv. Zinci Co.
Mist. Ipecac. Co. (Children's Section)	Mist. Ipecac. et Bellad. Infant.
Mist. Rhei et Magnesia (Children's Section)	Mist. Mag. Carb. et Rhei Aromat. Infant.
Lotio Benzyl Benzoate (Mellanby)	Applicatio Benzyl Benz.

Sport

Rugby

GUY'S *v.* ST. BARTHOLOMEW'S.

(At Chislehurst on October 9th.)

In this rather dull match we once again failed to get into our stride until the end of the second half. Then we overwhelmed the opposition and brought the score from 0–8 to 18–8 in a quarter of an hour.

Until this time the play had been lethargic and, although Guy's had most of the ball, we seemed unable to do anything right. In the first half we came near to scoring only once, when N. K. Macrae-Gibson's judicious cross-kick was knocked-on over the line.

Early in the second half Strathie broke through in characteristic style, but after a long run was unable to beat the full-back. It was not until N. K. Macrae-Gibson out-distanced the opposition to score from the half-way line that a change in our play occurred, and we scored three quick tries. Dwyer got the first from a three-quarter movement, which looked good after our previous play, Harvey the second following a strong run by Hildick-Smith, and Lee the last after Vidot had broken through. Lewis converted three of the tries and played his usual immaculate game at full-back.

Team.—T. L. T. Lewis; P. Dwyer, N. K. Macrae-Gibson, D. M. Strathie, G. Hildick-Smith; E. W. Graham, R. D. Willcock; A. Batty Shaw, A. B. Lee (captain), R. G. L. Brittain, C. F. Ziervogel, A. G. Albers, P. D. Harvey, C. Vidot, P. C. S. Campion.

GUY'S *v.* COVENTRY.

(At H.O.P. on Saturday, October 16th.)

The first visit of Coventry to Honor Oak Park since the War was undoubtedly one of the centenary year's attractions. They had not been beaten for two years and they left London with their record intact after beating the Hospital by 3 goals 2 penalty goals and a try to a goal and a try.

Territorially, the margin between the teams was not as great as this. The game was lost in the opening stages when Coventry were awarded a penalty in front of the posts and another near the half-way line, both of which Captain F. L. Gilbert placed over the bar. Following some relentless tackling Preece, the Coventry stand-off, went over for a try, which was made for him by Captain Gilbert, who followed up by kicking the goal, scoring a try himself and converting.

Guy's lost chances by fumbling and weak passing, but their second-half play was something like their true form, although a mistake by A. C. Macrae-Gibson allowed Sidwell, the Coventry wing, to slip through and swerve past Lewis for a grand try, which Gilbert converted.

Guy's hit back hard against a deficit of 21 points and, following a long run by Ziervogel, the ball came to Vidot, who crossed for an unconverted try. Guy's continued to press for quite a while until Strathie engineered a nice bout of passing with Boyd and succeeded in scoring an excellent try which Lewis converted, but Sidwell again crossed for Coventry and Captain Gilbert missed his only kick of the match.

If there is any criticism to be made Guy's forwards did not jump high enough in the line-outs, many of their three-quarter movements were too individualistic, which gave the Coventry defence little trouble, and there was too much hesitation when Coventry were attacking in Guy's "25."

Association

A PROMISING START.

The Hospital is partaking in the London University League this season; this has been divided into two groups. The two leading clubs in each will play off the semi-finals on March 4th, the final being on March 8, 1944.

The XI are so far unbeaten both in League and other matches; total goals for 64, against 13. The highest score was 19–0 *versus* Northampton Engineering College, of which C. B. Clarke scored 10. This is a record score for the League, including pre-war matches.

The XI are sorry to be without the services of J. Elder, last year's captain, who received an injury early in the season. Sykes has shown promise in his place at inside right.

Team.—N. J. Crane, E. G. Murphy, N. T. McNeil, C. S. Mathews (captain), R. D. Rogers, S. Stableford, R. Owen, R. Finney, C. B. Clarke, M. J. L. Sykes, F. R. M. Young.

RESULTS.

Sept. 18th.—Canadian Army H.Q.	..	3–2
,, 25th.—Winchmore Hill	.. ..	7–1
Oct. 2nd.—Bexleyheath	.. ..	6–1
,, 9th.—Malvern College	.. ..	2–2
,, 16th.—Alexandra Park	.. ..	10–5
League.		
Oct. 23rd.—Imperial College	.. ..	5–2
,, 30th.—Northampton Engineering College	.. ..	19–0
Nov. 6th.—Battersea Polytechnic	..	12–0

Hockey

GUY'S *v.* WESTMINSTER HOSPITAL

This game was played on October 31st at Wandsworth, on the Westminster ground in the precincts of the local asylum. The inmates were intrigued but were kept at a respectable distance providing quite the largest following we have had this year. Guy's forced the pace from the outset and soon scored two goals. After this the game rather lost interest being memorable only in the stringent views of the umpire on the question of obstruction.

Result, Guy's 4, Westminster Hospital 1.

Team.—A. G. Starte; B. H. Prideaux, D. C. Dawson; L. D. Carton-Kelly, J. G. Richards P. T. Parr; G. Thompson, J. D. Trethowan, T. C. L. Parry(Capt.), D. R. S. Saunders, G. Wotton.

GUY'S *v.* MIDDLESEX HOSPITAL

At H.O.P. on 6th November, 1943

Despite continual rain we were fortunate in having a very enjoyable match. Guy's took the lead from the start and within the first 15 minutes had scored 2 goals. Play was quite open and before half-time the score was 3-0. Guy's pressed hard right through the second half and two more goals had been added before Middlesex broke through for their goal. At the final whistle Guy's had won 6-1.

Team.—A. G. Starte; B. H. Prideaux, D. C. Dawson; L. D. Carton-Kelly, P. T. Parr, J. D Rumble; G. Thompson, C. J. Jenkins, J. R. Bunt, D. R. S. Saunders, A. Brown.

Hospital Information, etc.

Notices

EXAMINATION FOR TREASURER'S MEDAL AND PRIZE FOR CLINICAL MEDICINE.

August, 1943.

The following award has been made :—

J. O. Laws, Medal and Prize.

Guy's Hospital Medical School

MEDICAL REGISTRAR ACTING.

Applications are invited for the post of Medical Tutor and Acting Medical Registrar, to commence duties on January 1st, 1944. The post carries an honorarium for teaching of £50 per annum, and is held in conjunction with an E.M.S., B. 1 appointment at a salary of £340 per annum or £550 per annum, dependent upon experience. In either case with board and lodging or £100 per annum in lieu thereof. The successful candidate must be prepared to take up duties at Guy's Hospital or at one of the E.M.S. Hospitals in Sector 10. Applications should be lodged with the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, on or before November 27th, 1943.

DEMONSTRATOR OF ANATOMY.

Applications are invited for the appointment of Demonstrator of Anatomy (whole-time) to commence duties on January 1st, 1944. Salary at the rate of £300 per annum.

Applications should be forwarded to the Medical School Office not later than Friday, November 19th, 1943.

Blues

A meeting of the Blues Committee was held at Guy's on October 9th, 1943. The following suggestions for blues and half-blues were received and approved :—

Cricket Club.—Full Blues : D. C. Boyd ; D. R. S. Saunders ; G. W. Garland. Half-Blues : G. Thomson ; L. D. Carton-Kelly ; R. G. L. Brittain.

Tennis Club.—Half-Blues : R. G. Lomax ; S. A. Marsh.

Rowing Club.—Full Blues : R. T. Lowein.

Athletic Club.—Half-Blue : I. A. H. Munro.

Swimming Club.—Full Blues : D. J. Gray ; B. H. Pickard. Half-Blues : R. G. Iliffe ; R. A. Dean.

Pass List

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FIRST AND SECOND PROFESSIONAL EXAMINATIONS.

September, 1943.

Dental Metallurgy.

C. W. H. Williams

Dental Mechanics.

J. F. Bowes
G. T. Crook
D. W. Farren
M. C. Grant
C. M. M. Jenkins
R. T. Lowein
J. D. Rumble
A. J. Swann
A. J. L. Wheatley
P. J. R. Whyte

General Anatomy and Physiology.

T. L. Barker
L. D. Carton-Kelly
G. A. Kerr
W. O. King
A. A. W. Fooks
R. K. Foster
R. G. Iliffe
G. J. Marks
A. Shotts
J. R. Wallis

Special Anatomy and Physiology.

D. A. Barr
K. H. Brown
J. R. Burt
J. G. Davimes
P. Griffiths
P. C. Hanley
M. C. Hudson
D. J. Reid
H. I. Tozer
M. G. Trott
J. E. C. Weddup

CONJOINT BOARD.
FINAL EXAMINATION.

October, 1943.

Surgery.

*D. H. Broughton
A. S. Carruthers
*M. J. Cutler
M. E. Evans
K. M. Gough
M. D. Keates
*T. Koonvisal
J. Lorber
J. K. Morgan
*D. Rosenberg
*O. H. E. Williams

Midwifery.

*R. R. Burn
A. B. Dickie
M. E. Evans
K. M. Gough
I. S. Hodgson-Jones
T. C. L. Parry
J. S. Smith
A. B. Vanscolina
D. P. Wheatley

Pathology.

E. W. R. Alderman
M. A. Barker
J. B. Ebsworth
H. M. Emrys-Roberts
S. Freedman
W. T. Harrett
J. Lorber
B. C. Lee
D. J. Morton
P. F. Pearson
J. F. N. Sidebotham
J. D. Whitehouse
*J. Wedgwood

Medicine.

A. Bown
*R. R. Burn
*M. J. Cutler
*A. G. Ellerker
M. V. Guilmont
J. V. Kent
*P. G. Large
J. Lorber
*I. L. McKelvie
N. L. M. MacManus
*S. A. Marsh
*J. W. Robb
*W. H. Smith
J. M. Thomas
*J. R. Trounce
*J. Wedgewood
*C. F. Ziervogel

* Have completed the examination.

Mentioned in Dispatches

Sqdr.-Ldr. D. Stafford Clark.

Births

CLOUGH.—On Wednesday, October 27th, 1943, at Southend General Hospital to Lesley (née Matthews), of Hadleigh Road, Leigh-on-Sea, wife of E. Oldham Clough, Lieut., A.D. Corps—a son.

Missing

CUTHBERTSON.—Reported missing in action, October, 1943, Surg.-Lieut. Peter Slade, R.N.V.R., only son of Lieut.-Col. and Mrs. L. A. Cuthbertson, of Redhill, Surrey.

SHARPE.—Reported missing at sea, September 10th, 1943, Captain R. M. Sharpe, R.A.M.C., son of Dr. and Mrs. F. A. Sharpe, of Preston, Lancs.

EDS. { R.R.B. D.R.S.S.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

TIME has sped at an unprecedented pace since the first shock of the German offensive against Holland, Belgium and France. Dunkirk has entered history and is graced with a date,—Dunkirk, June 1940—so remote does it seem. The local Defence Volunteers formed at the time have evolved from the rather pathetic though gallant body which they were to the capable and efficient Home Guard of to-day. The greater part of the Medical School was at that time centred round Sherwood Park, and it was there that Guy's students were organised into what we hope, rather dubiously, would have been a body effective against an invasion. Until this time there had been no military training at the Hospital since the outbreak of war, when the London University Service Training Corps had to be disbanded. The spirit of the hour imbued members of the unit with intense enthusiasm; they—we—were almost too glad to spend the nights "guarding" key points armed with a small-bore rifle and six bullets amongst three men. Standing outside in the early morning, the guns rumbling fitfully in the distance, a single thought occupied the stillness: "Are they louder, nearer than before?" Surely a situation calculated to thrill even the most plethoric! It was a rude blow to the company when it was informed that no local scheme could be conceived which would allow for the holiday periods, and that, therefore, it was to be broken up.

The following summer, under the National Service Acts, all students were obliged to join some Civil Defence unit, exemption only to be granted on recommendation from the Medical School. A scheme was soon evolved at Sherwood Park which did allow for the coming and going of students and a large unit was levied. It is a happy English instinct that to be ordered to do anything unusual immediately invokes some resentment—"happy" in that it provides an additional reason why would-be Fuehrers meet with short shrift in this country. But the resentment was soon overcome by sane thinking, and a Guy's unit came to stay. Later, with the altered distribution of students, other units were formed at Guy's itself and at Farnborough.

At the present time the School authorities are willing to recommend a student for exemption from Civil Defence duties after a year of the clinical period in the case of a medical or in the final year for dental students. It is unfortunate that different views have been adopted by various hospitals on this particular question, so that whereas at one the student may compulsorily spend the whole of his student career doing such duties, at another he may be exempted so soon as he enters the wards. There would seem no adequate reason why the University authorities should not be asked for a definite ruling on the point. However, it is to be hoped that students will not claim exemption unless they personally are convinced that their professional studies will suffer. It is ultimately, as a correspondent has put it, though in another context, a matter of individual conscience.

Within the last few months measures have been taken to restart the London University Senior Training Corps. At the moment the necessary instructors are not available, but a number of students are receiving an intensive course to provide these. The Corps will commence training on the line of pre-War days early next year. In bare outline its function will be to prepare personel (*Nota Bene*, A.P.H. !) to take Certificate A, a combatant qualification, at the end of twelve months, to be followed at the end of the second year by Certificate B. The latter deals with organisation in the R.A.M.C. and equivalent services; to have obtained it will exempt the candidate from a certain amount of preliminary training on entering the Forces. After this examination each man will attend just sufficient parades to keep the knowledge fresh in his mind.

THE results of the last London M.B., B.S. final examination are published in this issue. We were stimulated to do a little private research into the number of Guy's men who have gained honours at this examination in the past. After tediously studying the results as far back as 1933 we gave up. During that period no one was recorded to have honours in two subjects, and only one—or was it two ?—in a single subject. As will be seen, J. R. Trounce passed with honours in Medicine and Pathology. He is to be congratulated and we wish him similar success in the higher examination.

Extractions

The Presidential Address to the Dental Society, by K. E. Pringle, L.D.S.

GENTLEMEN,—It gives me very much pleasure to read this paper, partly because it is on a practical subject, which is very much our problem, and partly because being among friends, I hope I can speak with considerable freedom. I will not take the whole subject: the methods of carrying out straightforward extractions are set out in text-books and are covered by the courses here. Again, the really difficult extraction is a matter for the expert; let us watch him with admiration and then leave our worries to him. To-day I will tackle the subject from several points of view and at the end refer particularly to those extractions which are not quite straightforward and are yet not really difficult.

In the recent past in England there have been far too many teeth extracted unnecessarily, while, on the Continent, far too many teeth have been kept beyond their time. Perhaps soon we may be able to reach a mean between these two points of view, where balanced judgment would be possible and only those teeth which can be proved to be offenders are removed. All things have their proper time to die, to depart. Let us allow teeth to do the same.

How are we to judge what is the right moment? This is our problem as dental surgeons. Of course, the majority of decisions we have to make are not difficult. The firm young tooth has only one problem, if there is any problem at all, and that is caries. What is the best way to conserve it? And the loose pus-circled tooth which asks for extraction also calls for little reflection on our part. The cases on which it is always difficult to decide are those in which the patient has some mild or chronic general condition, which might be attributed to the teeth and yet the teeth and gums show some, but not great, signs of infection. For example, the teeth are firm, but there is somewhat more gingival recession and alveolar absorption than is normal for a person of that age, or X-rays show that several devitalised teeth have thickening of the peri-odontal membrane or slight osteitis at the apex. What should we bear in mind in reaching a decision? First, the long list of diseases which have been attributed to dental sepsis, and the large number of people who have been cured by the extraction of infected teeth. Secondly, the very much larger number of people who have not been cured by the extraction of their teeth. Thirdly, the quite considerable number of people who have been made utterly miserable by the extraction of all their teeth. Fourthly, that any evidence of dental infection is as likely to be an index of the patient's past general health as it is to be the cause of his present ill-health. Fifthly, clinical evidence is still of more value than X-ray evidence, which must only be used for confirmatory purposes. And, lastly, that in many cases we simply do not know whether the patient will benefit; we should, therefore, proceed with caution, extracting only one or two teeth at a time and making cultures if it seems advisable.

A question about the extraction of temporary teeth which one is often asked is this: "You say that extraction of temporary teeth causes all kinds of dental irregularities. Does that mean that you would keep septic temporary teeth to save this happening?" The answer to this is, of course, "No"; and one can make it a general rule that where caries has involved the pulp, a temporary tooth should be removed. This is, however, *no* excuse for removing temporary teeth where the caries has not involved the pulp. If we can, we must fill temporary teeth, but if this is not possible we should stone the enamel to make the cavities as self-cleansing as possible and then apply silver nitrate. Let us have absolutely nothing to do with the edict issued to school dentists some years ago: "Extract the Ds to save the Es." Such folly can only result in large numbers of children developing a deep incisor overlap with resulting traumatic occlusion in the incisor region, which will cause them to lose the incisors years earlier than is necessary. There is no easy way out. We have to preserve the temporary dentition and it is worth saying that those who do try to do this derive considerable satisfaction from seeing the dental arches of their young patients developing as normally as possible and also realising how many are the orthodontic headaches which they are saving themselves. Having said all this, I should like to record that in cases where the arches are developing quite normally, once a correct antero-posterior relationship of the incisors has come about there seems to be less risk from extraction of the temporary teeth than in cases where the arches are small or there is postnormal occlusion. After eight years of age the extraction of temporary teeth is not of such vital importance to arch development.

Now, as to the extraction of temporary teeth for orthodontic purposes; given that it is best to remove any temporary tooth that is clearly preventing a permanent tooth from reaching its proper position, let us bear in mind that there are considerable dangers in removing temporary canines in order to straighten erupting incisors. One is that growth in the area of the extraction stops or is at any rate slowed down very considerably. The result of this is that although you may have straight incisors there will be flattening of the arch, very often a tilted lateral incisor, and, as a rule, an outlocked canine, which has to be dealt with later. Another is that if it is a lower canine there will be an actual dropping back of the lower incisors, followed by their secondary over-eruption with a resultant deep incisor overlap. From observation of quite a number of cases I should say that frequently where only upper temporary canines have been removed the stoppage of growth has not been limited to the upper arch; the lower has been confined, too. Advocates of this method might say that you can always remove the first premolar to provide room for the outlocked upper and lower canines, but where a lower premolar has to be extracted the deep incisor overlap becomes permanent, with resultant traumatic occlusion for the incisors and sometimes secondary proclination of the upper incisors. In fact, you can cause orthodontic cases in this way. Be careful of extracting temporary canines. Quite often slight irregularities of the incisors right themselves if left alone and, if this does not happen, you can still remove the upper first premolars just as the canines erupt. Be very careful about removing lower first premolars.

We now come to the extraction of permanent teeth for orthodontic purposes. In England we are much addicted to removing teeth to provide room, as opposed to the Americans and Continentals, who usually employ expansion for this purpose. Here I should like to mention one very important consideration; that from the point of view of our nation extraction is undoubtedly the best method in most cases, for when we use expansion our cases relapse, but it may well be that in other races different climates bone development is quite different and expansion may give more permanent results.

This is not the time to go into all the orthodontic conditions for which extractions are used, but I should like to say a word on the subject of the extraction of all four first permanent molars. This method of treatment is advocated very strongly by Mr. A. A. Wilkinson, who claims that it reduces caries (which it certainly does, as the first permanent molars are the teeth most liable to caries) and overcrowding. He advises that it shall be carried out at eight or nine years of age. He does, however, admit certain exceptions:—

(i) Cases where temporary teeth have been extracted early.

(ii) Cases of postnormal occlusion.

(iii) Cases of prenormal occlusion.

(iv) Cases where permanent teeth are absent.

As these represent something like 90 per cent. of the cases we see here, this makes things a little easier. Of the remaining 10 per cent., quite a few must have absolutely normal arches, and one is left with cases of normal arch relationship where there is a tendency to overcrowding. What, generally speaking, are the alternative lines of treatment?

(i) Expansion of the arches. This often relapses.

(ii) Extraction of upper first premolars only. This leaves the lower teeth crowded and thus liable to caries and paradontal troubles.

(iii) Extraction of upper and lower first premolars. This gives a permanent deep incisor overlap, with resultant traumatic occlusion.

(iv) Leaving the case alone. This gives liability to caries and paradontal troubles and is not æsthetically perfect.

Therefore, within this rather limited sphere, there is a case to be made out for extraction of all the first molars, but we have to bear in mind that this results in rather narrow arches and that no other orthodontic work with appliances can be carried out until other teeth erupt. It is also well to note that if the extractions are carried out after the age of eight or nine, there is a considerable risk of tilting of the lower second molars with resulting danger areas between the second molars and the second premolars. If cavities appear there they are more difficult than any others to fill satisfactorily. Personally I have not seen any cases where the extractions were carried out as early as eight, but the models shown by Mr. Wilkinson at a recent meeting showed quite good

occlusion, if not absolutely perfect as regards the lingual and palatal cusps. Incidentally, as far as I have observed, the claim, by opponents of this idea, that the bite will collapse with extraction of lower first molars is incorrect. It will only collapse if temporary teeth have been removed early, and then not always permanently. From the point of view of incisor overlap, extraction of lower first molars is much less dangerous than extractions farther forward. Actually, if we are not too pedantic, there are occasionally other cases—certain Angles class II, division 2, cases with crowded lower incisors and certain class I cases which have lost temporary molars early, where extraction of the four first permanent molars gives less harmful results than any of the other lines of treatment available, but this can never be advised without first considering all the other lines of treatment, and it is most unwise to make any general rule about it.

Before we consider technique I must say a word about nitrous oxide anæsthesia. Anæsthetists, usually intensely practical men, do not always seem to realise the nature of the drug which they are administering, but it is well to bear in mind that nitrous oxide given in a gentle manner can for many people give what some might call dreams which are of a peculiarly vivid nature and, in some cases, are akin to revelation. It is one of our tragedies that these dreams cannot be remembered for more than a second or two after the patient returns to our mundane world. We must remember this even if we are in a hurry.

Now for some points of technique; first, the extraction of impacted premolars. The impacted premolar is almost without exception caused by early loss of temporary teeth, followed by the movement of adjacent teeth closing the gap. There are some who say that an impacted and unerupted premolar should be surgically removed, whether it is causing trouble or not. To me this has always seemed an unnecessary operation, and I cannot recall one case where a tooth of this kind gave any trouble through being left. The advice is, therefore, to leave impacted premolars until they are sufficiently erupted to be grasped in forceps or, if it seems desirable from an orthodontic point of view, to remove the first molar or first premolar. Incidentally, in the lower jaw the first molar is usually a better tooth to extract than the first premolar, so as to save that backward drift of lower incisors and secondary deepening of the incisor overlap. In the upper jaw the first premolar is more often chosen than the first molar.

Now as to the extraction of the partially erupted but impacted second premolar local anæsthesia is usually better as the prop tends to get in the way under "gas." Where the premolar is lingually or palatally impacted, apply Reed's forceps, working with the handles over the teeth on the opposite side. Apply the blades as far down the crown as the adjacent teeth allow. With the left hand support the adjacent teeth firmly. Now apply a gentle rotating movement to the forceps, rather like that used with a ratchet screwdriver. Do not attempt to move the tooth buccally and lingually, as with a normal extraction, but keep on with this backwards and forwards rotary movement. If you persist the tooth always comes out. Where the premolar is buccally placed, which is less usual, application of Reed's forceps on the mesial and distal sides is sometimes useful; again the rotary movement is used, and again the adjacent teeth are supported.

Where the premolar is vertically impacted, so that the crown is larger than the space above it, application of lower root forceps is difficult and a danger to the adjoining teeth. Although it is perhaps worth trying to ease the tooth out buccally or lingually, the most practical procedure is to remove the crown of the premolar by means of a fissure bur used across the neck at right-angles to the long axis of the tooth. Use a bur sufficiently large to allow space for the crown to drop down before it is worked out buccally or lingually. When the crown has been removed the root usually presents little difficulty. If necessary, a Coupland chisel can be used to ease it out a little.

Next, outstanding canines. You will find that many are loth to extract outstanding upper canines because, as they rightly say, the extraction of the upper canine causes a flattening of the face in that area. Extraction of the first premolar, or the lateral if the canine is placed right over that tooth, with alignment of the canine, are considered preferable. But, to my mind, there are exceptions. Where the canine is so outstanding that the lateral is hard up against the buccal cusp of the first premolar and the first premolar is actually situated in the position which the canine usually occupies, it is best to extract the outstanding canine. The premolar, being in the canine's position, keeps that part of the face from becoming flattened. But one word of warning: do not extract the outstanding canine if by so doing the palatal cusp of the first premolar will be visible, for this can be very unsightly.

As to the extraction of the outstanding canine, it is quite useful to ease it a little with a Coupland's chisel, but the extraction is usually carried out by applying the blades of rather narrow upper straight forceps on to the mesial and distal aspects of the root. The adjoining teeth are protected as far as possible by the first finger and thumb of the left hand and the same backwards and forwards rotary movement is applied to the tooth as in the case of the impacted premolars. Outstanding lower canines are removed by applying narrow-bladed lower root forceps in the ordinary way or by applying Reed's forceps to the mesial and distal aspects of the root and using the rotary movement.

Canines impacted in the palate are usually very difficult to remove, but it is a good principle to allow them to show at least a part of the crown above the gum before attempting to remove them surgically.

We have talked a good deal about using Reed's forceps on misplaced teeth, but I would here like to put in a plea for their use in extracting upper molars. In my time as a student we were told that Reed's were useless and dangerous for the upper molars, in that you were likely to break off the crown, leaving the three roots joined. Bayonets were, however, said to be mechanically correct as you could drive up the palatal and one of the buccal roots and you were thus sure, if there was a breakage, of getting two roots at least. Well, now, that was fifteen years ago and I must say after trying it myself and watching others, that this teaching, which still seems to be in vogue here, seems to me quite inaccurate and also that the bayonet forcep is a very poor instrument for the removal of upper molars and temporary molars and even bulbous premolars. That does not mean that the bayonet is not very good for removing single roots for that purpose it is excellent. The snags in the bayonet theory are these :—

(i) The buccal and palatal roots of the upper molar, and particularly the temporary molar tend to diverge. Therefore, as you push up with the bayonet forcep, you only grip the tooth with the ends of the blades. The farther you push the wider apart become these points of contact and the wider apart become the handles. If you try to bring the handles together you simply slide down the inclined planes of the roots.

(ii) As the blades of the forceps are opposite each other and the palatal root is not opposite either of the buccal roots you cannot even get a stable hold on two roots.

(iii) All this pushing hurts the palm of your hand.

Now, if you use Reed's forceps, which have converging blades, you grip the tooth at the junction of roots and crown and you *take it out.*

In the extraction of lower right molars the position of the operator is most important. To obtain the greatest possible leverage on the tooth you have to work with the body upright and with the forceps, wrist and forearm at right-angles to the long axis of the tooth. The forearm is kept close to the body and the angle at the elbow is also a right-angle. A stool is a great help in obtaining the extra height necessary to achieve this position. If you apply the forceps in the stooping position this is all that is necessary, for from that time onwards, if you straighten your back, the hand holding the forceps can feel the movement of the tooth.

This question of feeling and sensitiveness in the fingers and hands is most important to the dentist. For example, if you are drilling a cavity, the hand knows quite well which part of the tooth the bur is on and can even distinguish between normal dentine, hard caries and soft caries. Sensitiveness in the hands is a thing to be cultivated.

When dealing with broken-down molars where the lingual wall has gone, it is sometimes useful to use lower root forceps with a long lingual blade, but if teeth are really broken-down separation of the roots is most useful in order to avoid trauma. You can separate roots by burring, but the root-splitting forceps still to be seen in the gas room are really excellent for doing this job and can often make a really difficult extraction into quite a simple one.

Lastly, a few words on the removal of small pieces of root and apices. It is often better if a tooth is broken during an extraction to leave the removal of the root for two weeks, rather than driving up and up with forceps in the hope of connecting with the root. If the piece is X-rayed and the job is tackled quietly two weeks later by means of an incision and reflection of the gum you will find your root quite loose and easy to

remove, owing to the mild infective process that has been going on during the interval. The principle to be applied in extracting a root is to obtain good access and a good view. Given this, the question of how to remove the root usually solves itself.

If there is any theme running through this paper, it is this: "Try to do every operation with the least possible use of force," but as no presidential address is complete without a quotation I will let Chuang Tzu of ancient China speak on this subject:—

Prince Hui's cook was cutting up a bullock. Every blow of his hand, every heave of his shoulders, every tread of his foot, every thrust of his knee, every whshh of rent flesh, every chhk of the chopper, was in perfect harmony—rhythmical like the dance of the Mulberry Grove, simultaneous like the chords of the Ching Shou.

"Well done!" cried the Prince. "Yours is skill indeed!"

"Sire," replied the cook, "I have always devoted myself to Tao. It is better than skill. When I first began to cut up bullocks, I saw before me simply *whole* bullocks. After three years' practice I saw no more whole animals. And now I work with my mind and not with my eye. When my senses bid me stop, but my mind urges me on, I fall back upon eternal principles. I follow such openings or cavities as there may be, according to the natural constitution of the animal. I do not attempt to cut through joints—still less through large bones.

"A good cook changes his chopper once a year—because he cuts. An ordinary cook once a month—because he hacks. But I have had this chopper nineteen years and, although I have cut up many thousands of bullocks, its edge is as if fresh from the whetstone. For at the joints there are always interstices, and the edge of a chopper being without thickness, it remains only to insert that which is without thickness into such an interstice. By these means the interstice will be enlarged, and the blade will find plenty of room. It is thus that I have kept my chopper for nineteen years as though fresh from the whetstone. Nevertheless, when I come upon a hard part where the blade meets with difficulty, I am all caution. I fix my eye on it. I stay my hand and gently apply my blade until, with a hwah, the part yields like earth crumbling to the ground. Then I take out my chopper and stand up, and look around, and pause, until with an air of triumph I wipe my chopper and put it carefully away."

"Bravo!" cried the Prince. "From the words of this cook I have learnt how to take care of my life." (*Taken from "Musings of a Chinese Mystic."*)

Thank you, gentlemen, and I hope this will be a very successful year for Guy's Hospital Dental Society.

Constipation in Infancy

By N. M. JACOBY.

I AM often asked what purgatives I favour for the infant. My reply is very simple. "None at all." But, says the questioner, "Surely constipation is bad for a baby," and to this I reply, "I have signed many death certificates for infants with diarrhœa, but none for those with constipation." The crux of the matter is that infants never suffer from constipation as a disease, but only from constipation as a symptom. Moreover, one can be dogmatic and say that the symptomatic treatment should never be purgation, and that treatment of the primary cause will soon set the trouble right. Let us then consider these primary causes and their respective treatments.

1. *Intestinal Obstruction.*—This is by no means common, but it comes first as it demands urgent recognition. This is usually easy as the signs are much like those in adults. It is a good thing to remember that on digital examination the rectum is empty and that, on withdrawal, the finger stall has no fæculent smell.

Treatment is surgical.

2. *Underfeeding.*—This is extremely common and very easily recognised by the fact that the child is receiving much less than 50 calories per lb. feeding weight per day. Sometimes the actual feed given is adequate, but on account of vomiting the amount passing through the pylorus is much reduced. Thus occurs the constipation of pyloric stenosis. An additional help in diagnosis is the nature of the stools, which are small, dark green and friable.

Treatment of the simple cases consists merely of increasing the feeds by small amounts daily till the requisite caloric intake is reached. In cases of vomiting, treatment is directed exclusively to stopping it. Purgation here would be reprehensible.

3. *High Protein Feeding.*—This is also very common and is seen mainly in infants fed on full cream dried milk. It may also sometimes occur when half cream dried milk is used. The stools are pale, hard and well formed.

Treatment consists of reducing the concentration of milk powder by about 10 per cent. and adding sugar in the ratio of 1 dr. to each 4 oz. of the liquid mixture. Slight variations in these quantities will soon produce a stool of the desired consistency.

4. *Low Fluid Intake.*—This is probably much rarer than is generally supposed. If the fluid intake is much less than 2 oz. per lb. body weight per day, it may be the cause of the trouble, and the treatment consists of " adding more water to it."

NOTE.—A combination of causes 2, 3 and 4 is frequently encountered.

5. *Anal Fissure.*—This is commonly found in conjunction with high protein or under-feeding. In the process of straining to pass the hard stools, the anal margin is torn. Subsequent defæcation is painful, and is thus performed as infrequently as possible accompanied by much screaming. It may be noted that the stools are smeared with bright red blood. Unfortunately, these infants are frequently given purgatives, when the result is somewhat akin to firing a 4.7-in. shell through a 3.7-in. gun.

Treatment consists of correcting the diet, giving liquid paraffin m.x. after each feed and applying Ung. hamamelidis to the anus.

6. *Intestinal Stasis.*—In infants this is a temporary phenomenon associated with some other condition such as cretinism or pneumonia.

The treatment, of course, is directed entirely towards the primary disease, and especially in the case of parenteral infection, remember that purgation may prove fatal.

7. *Following Diarrhœa.*—If an infant has had an attack of diarrhœa, recovery therefrom is frequently followed by a period of constipation. This is presumably due to the gut taking a rest after its previous over-activity. No treatment is required, as the condition rapidly cures itself.

Thus it can be seen that all forms of constipation in infancy can be cured without ever resorting to purgatives. Mainly is this due to the fact that an infant takes no interest whatsoever in its bowels. It does not develop headaches or anorexia if they are not opened daily. No infant ever asked for a purgative; none ever took one voluntarily; none need ever be given. Surely adults have something to learn here.

Guy's Letter

WINTER is once again closing in upon Guy's and combination of blackout and fog make any movement, except underground, dangerously traumatic. With the change of season comes a change of residents. Masters, Ticehurst and Glover leave us for the Services, whilst McCallum, Figgis, Cutler and Fabricius have disappeared into the Sector; in their place we welcome Humphreys, Hollis, Harvey, Macrae-Gibson and Trounce.

The gloom of winter, however, does not seem to have interfered with social activities. A dance has been held in the Nuffield Nurses' Home; it concurred with the results of the qualifying exam. and, as may be well imagined, it was far from dull. A few days later a Maids' dance was given, which was also well attended.

Among the many difficulties due to war conditions there is one which could easily be remedied. After the Pathology laboratory staff have gone home it is impossible for a houseman to do such investigations as the examination of a blood smear or the estimation of blood sugars. Surely a small room could be set aside somewhere with the equipment for carrying out these manipulations.

Finally, we congratulate David Gullick and Evelyn Norton on their marriage and wish them every success. J. R. T.

Correspondence

RUGGER CENTENARY DANCE.

To the Editor of the GAZETTE.

SIR,—Mr. G. Haslewood, from the relative safety of his rural surroundings, writes of the "great sacrifices, dangers and discomforts" which the majority of Englishmen are undergoing. It is general knowledge that those at Guy's, whether junior staff, house officers or students, have not only experienced considerable danger and discomfort, but work far harder and for longer hours than in peace-time and have relatively little free time for exercise or entertainment.

Mr. Haslewood's contention that the Rugger Centenary Dance is sabotage of the war effort is too ridiculous to need contradiction. The Government have decided to make available certain limited facilities for pleasure and recreation, a decision apparently which Mr. Haslewood would like to override. I am sure that most Guy's men will strongly resent the pompous and self-righteous attitude displayed in his letter. I can only regret, Mr. Editor, that you thought it necessary to waste the limited paper supplies of the *Gazette* by printing it.

Yours, etc.,

J. J. CONYBEARE.

Nuffield House,
Guy's Hospital, S.E.1.

To the Editor of the GAZETTE.

SIR,—All who know Dr. Haslewood like him too much to take his political views too seriously, but it is a little alarming to see the dim shape of would-be black (or brown) Fascist dictatorship peering through the red we had just got used to. I cannot boast of Dr. Haslewood's familiarity with night clubs, but I seem to have missed, in the hotels and restaurants which I visit, those "throngs of anti-social persons" he tells us fill them. Perhaps it is because I do not consider leave parties, or even normal civilian relaxation, particularly anti-social. I am not quite clear whether it is to the Rugger Dance itself or to the quite reasonable price of a guinea that Dr. Haslewood objects, but such phrases as "exploiting and flaunting their economic advantage" and "something not far removed from sabotage" seem to me, by their foolish exaggeration, completely to remove whatever point Dr. Haslewood's letter may have had.

Yours, etc.,

E. G. SLESINGER.

To the Editor of the GAZETTE.

SIR,—Mr. Haslewood is to be congratulated for his courage in taking up what he well knew could only be an unpopular stand in the matter of the Rugger Dance. Our present day and age has been plagued with far too much humming and hawing and failure to speak one's mind, though since Munich it is good to find that the perils of lack of moral courage have been recognised and that our opportunity to make recompense as a nation has not been lost. Mr. Haslewood has, however, rather confused the issue in his diatribe against "spending" and "leisure" generally, and he might do well to ponder the following facts. Firstly, it is a fact that civilian manpower in general is stretched to the limit and relaxation of some sort or another is imperative, and if, say, the Services and factory workers are entitled to their shilling or half-crown dances of the village hall or *danse palais* type, there is no reason why those willing to pay a much greater sum for virtually the same entertainment should not do so. Quite frankly I have always had the impression that there is much more genuine fun and happiness seen in the "bob hop" function than in those costing thirty or forty times the price, quite apart from the purgatory of bawling for non-existent taxis, etc., which is the painful sequel of these grander and later war-time functions. Secondly, Mr. Haslewood should remember that, under the workings of E.P.T. and other direct tax imposts, a large part of the guinea will be ploughed back into the Exchequer for the benefit of those less fortunately situated in life than medical students, so he need have no great anxiety on this score.

The point *really* at issue is, if the gentlemen concerned *honestly* feel that they have been working hard enough, at what is to be their job in life, then they can attend such a function with a clear conscience without feeling that in so doing they are depriving others of similar enjoyment of this nature. As an old Guy's man I hope they are in a position to feel this way about the matter as "slacking" under present conditions is intolerable and, amongst students, enjoying reservation as such, it would be despicable. Mr. Haslewood is also a little confused about spending and he might like to ponder on the answer to my final point before it is fired at him by a less well-intentioned critic. If X. buys a bottle of whisky at 25*s.* 9*d.*, approximately three-quarters of which sum is tax and goes direct to the Exchequer, is he more, or less, patriotic than Y., who buys a war savings certificate by which the Government is obligated to repay the original sum with a material addition after a period of years? The Ministry of Information were diffident in giving an answer when I put this point to them, but none the less I hope that on the night of the Dance I shall be in a position to enjoy my whisky-and-soda in my own home after a hard day's work with the same contentment that the Rugger celebrants terminate their—I hope hard—day's work in their chosen way.

Yours, etc.,

ROBERT CUTLER.

To the Editor of the GAZETTE.

SIR,—The Dance at Grosvenor House to celebrate the centenary of the Rugger Club will give an opportunity to many old Guy's men to meet together. All these old Guy's men are making their maximal war-effort and many are in the Services; and, because they are old Guy's men, with the traditions of the Hospital and the Rugger Club behind them, all who can will seize this rare chance in war-time to renew old acquaintances. For the modest sum of a guinea their girl-friends—or even their hard-worked wives!—may share this reunion and relaxation.

Would Dr. Haslewood deny these people an evening's enjoyment between the hours of 9.30 p.m. and 1 a.m. after a hard day's work or during their Service leave? It would appear that Dr. Haslewood has little knowledge of, or respect for, Guy's tradition, and that he would hardly appreciate the views so admirably expressed in the leading article of your last issue. The Dance is not intended primarily for students; but I venture to suggest that by attending they might acquire something of the Guy's spirit which is tending rapidly to be lost as the result of the present isolation of the Medical School. A guinea, even in war-time, would be well spent in achieving this result.

It is my sincere hope that the Rugger Club Dance will be a great success. I shall go to Grosvenor House, but I should prefer Dr. Haslewood to occupy a soap-box in the adjacent Hyde Park rather than flaunt his political ideas in your columns under a guise of injured self-righteousness.

Yours, etc.,

S. H. WASS.

Nuffield House,
Guy's Hospital, S.E.1.

Sport

Rugby

GUY'S *v.* ST. THOMAS'.

(*Played at H.O.P. on October 23rd.*)

Result: Guy's, 14 points; St. Thomas' Hospital, 8 points.

In their first meeting for two years Guy's Hospital beat St. Thomas's by one goal and three tries to one goal and one penalty goal. In the first half Guy's were forced back to their own half, largely due to the excellent rushes of St. Thomas's pack and to the support they received from B. T. W. Ritchie at full-back. His handling of a wet ball and his kicks to touch demonstrated that he was the best full-back against whom we have played this season. In the second half the Guy's backs handled better and received a regular service from the scrum, where Lee's regular hooking became monotonous. W. H. Davis scored early for St. Thomas's and the try was converted by Ritchie. Towards the end of the game Boyd gathered a cross kick from one of the defenders and scored far out. Hildick-Smith, A. C. Macrae-Gibson and E. W. Graham scored further tries, one of which was converted by Dean. The match closed with a few dangerous movements within the Guy's "25," but none of these were converted.

GUY'S *v.* RUGBY SCHOOL PAST AND PRESENT.

Invitations are still open for Guy's men to attend the match at Rugby School on December 4th between Guy's and Rugby School Past and Present. They will be welcome at dinner in the evening. There is a suitable train to London later in the evening. Those who are able to be present should write to R. E. Smith, M.D., The Sanatorium, Rugby School, Warwick.

Hospital Information, etc.

Notices

STUDENTS' DRAMATIC SOCIETY.

The Tunbridge Wells Students' Dramatic Society is producing the play, "Ten Minute Alibi," by Anthony Armstrong. Performances will be given at the Convent of the Sacred Heart, Pembury Road, Tunbridge Wells, on Friday, December 10th, at 7.30 p.m., and on Saturday, December 11th, at 2.30 p.m. and 7.30 p.m. Tickets are available at 2*s.* 6*d.* and 1*s.* 9*d.*, and may be obtained from E. L. Leiser (Hon. Sec., Dramatic Society), 1, Beulah Road, Tunbridge Wells.

Pass List

UNIVERSITY OF LONDON.
THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.
October, 1943.

Honours.

J. R. Trounce
Distinguished in Medicine and Pathology.

Pass.

B. B. Alhadeff
D. H. Broughton
R. R. Burn
A. G. Ellerker
K. M. Gough
J. Hart
I. D. Henderson
P. G. Large
J. A. Riddle
W. H. Smith

PART I.

R. A. Allen
F. B. S. Barkworth
D. E. M. Brown
M. E. Evans
D. D. Forbes
J. Fry
C. O. Fung-Kee-Fung
A. J. P. Graham
O. M. Jonathan
J. V. Kent
H. J. Lewis
K. A. MacDonald
E. H. Osborn-Smith
H. A. Philcox
N. J. Shah
R. C. W. Thompson

PART II.

C. O. Fung-Kee-Fung
A. B. Lee
R. Merryweather
J. K. Morgan
W. S. Morgan
J. B. Musgrove
A. M. Rajah
D. Rosenberg

PART III.

P. Brightwell
E. H. Couper
M. D. Cremin
M. J. Cutler
W. C. Johnson
A. J. P. Oldham
D. R. S. Saunders
A. W. P. Stone

ROYAL COLLEGE OF SURGEONS.
L.D.S.
FINAL EXAMINATION.
October, 1943.

PART I.—Surgery.

C. G. Bason
D. C. Boyd
H. S. M. Crabb
J. G. Davimes
D. C. Dawson
J. H. Farrell
P. J. Hill
D. T. Humphris
J. A. Ireland
G. F. King
J. B. Kyle
L. J. Leggett
P. T. Parr
S. C. J. Pink
D. J. Rayner
J. G. Richards
J. S. Spencer
I. T. M. St. George
R. D. W. Stileman
B. H. Taylor
D. E. Williams

PART II.—Dental Surgery.

J. Bunch
T. P. Dalton
P. D. Harvey
G. F. King
N. A. Lee
M. M. Levene
H. Mistlin
F. B. Sartory
P. J. Wardell

Papers by Guy's Men

Rushton, M. A. Oxford vaporiser for endotracheal Anæsthesia. *Lancet*, 1943, ii, 599.

Rumball, C. A., Nancekievill and Another. Sternal puncture in the Diagnosis of Malaria. *Ibid.*, 468.

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Bray, George W. Allergy. *Practitioner*, 1943 **141**, 210.

Stamm, T. T. The diagnosis and treatment of the common causes of pain in the foot. *Post. Grad. Med. J.*, 1943, **19**, 231.

Forman, L. Acanthosis Nigricans with Discrete Warts and Marked Mucous Membrane Changes. *Proc. Roy. Soc. Med.*, 1943, **36**, 611 (Sect. Dermatol).

Crisp, E. J. The Mechanism of Valgus Foot Strain. *Ibid.*, 606. (Sect. Physical Med.)

Rewell, R. E. Potassium concentration after Ischæmia of Muscle. *Brti. Med. J.*, 1943, ii, 483.

Herbert, W. E. Histological Examination of Two Teeth treated by Root Resection. *Brit. Dent. J.*, 1943, **75**, 205.

Bowen, W. H. The Ætiology of Appendicitis. *Brit. J. Surg.*, 1943, **31**, 127.

Vine, R. S. Medical Officer of a P.O.W. Camp. *J. Roy. Army Med. Corps*, 1943, **81**, 128.

Whitwell, G. P. B. Dermatitis from cutting oils. *Lancet*, 1943, ii, 394.

Hurst, Sir Arthur. The hysterical Nature of so-called Pernicious Vomiting of Pregnancy. *Clin. J*, 1943, **72**, 169.

Change of Address

F. D. Annesley, Brigadier, R.A.M.C., Messrs. Glyn, Mills & Co., Kirkland House, S.W.1.

H. M. Brown, Major, R.A.M.C., H.Q. Amgot, 15 Army Group, C.M.F.

P. G. Epps, Ft.-Lieut., No. 2 R.A.F. General Hospital, B.N.A.F.

Missing

Missing from October 3rd, 1943, in Middle East, Captain P. M. Calder, Army Dental Corps. Any information gratefully received by Miss Calder, Sellers Hall, Nether Street, N.3 (Tel.: Finchley 2735).

Deaths

MICHAEL.—On November 20th, 1943, at 713, Kenton Lane, Harrow Weald, Cyril Eden Michael, M.A., M.B., C.C.Camb.

OWSLEY.—On November 11th, 1943, George Chetwode Owsley, M.D., of 5, Montpelier Row, Blackheath, S.E.3, aged sixty-nine years.

SILK.—On November 18th, 1943, at Trinity Nursing Home, Torquay, Dr. John Frederick William Silk, late of London and Dartmouth, aged eighty-five.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THE wise man, before committing himself to heavy expenditure, first considers whether his purse is deep enough or no. Thus, we read with some little apprehension of the recent call-up orders for newly qualified medical practitioners—50 per cent. of those holding "A" or "B" house appointments, to leave civil practice.

This war is unique in so far as it is total. Its totality springs from the extreme complexity of our modern civilisation, that jig-saw puzzle whose pieces do not realise that the whole is greater than the part.

What have jig-saws to do with call-up orders? Whilst hesitating to criticise those with the facts before them and with knowledge of the portentous events of the future, we feel that a goodly proportion of those doctors affected by the call-up might have been more valuable on the home front, where the ranks are filled with such devotion, patience and self-disregard, by men who have been prematurely aged by the fatigue of the struggle, and by those who have returned to repair the gaps in the widening ranks. Since we acknowledge the existence and importance of the home front we must not allow it to be neglected and hindered by ill-health. For we must realise the fact that a doctor's duty is very largely that of maintaining good health besides the minor but more dramatic (and remunerative !) one of curing ill-health.

Ill-health means absenteeism from the lathe, the coal-face, the dock-side, the railway siding as well as from the gun-site, the Churchill tank, the bomb-aimer's seat and the ship's engine-room. Factory-workers and land-girls march with Service men before our leaders in Victory Parades as a symbol of national unity of purpose, but demonstrating a unity of necessity.

Civilian morale is largely dependent upon physical well-being, and he would be rash who would deny the importance of maintaining that indefinable psychological state of equilibrium whose disturbance Dr. Goebbels acknowledges to be one of his chief aims. Therefore to maintain that equilibrium, must we look to our home front and safeguard its integrity; for what soldier, no matter how well he is looked after, will give of his best if he is haunted by the thought of his wife ill at home and ill-cared for with not enough doctors to attend her or his little son who must soon become a piece of that jig-saw puzzle ? The physician builds for the future, too.

It may justly be retorted that the home front has held together remarkably well for four years of war without any signs of cracking, aided by gradually thinning ranks in the medical profession. This integrity may show that there were too many doctors before the War or that those left behind have performed superhuman tasks in maintaining the equilibrium . It may be that this new order will provide the last straw. That remains to be seen. However, facts count and we must see in this action of the Medical Personnel (Priority) Committee a step taken only as a result of mature deliberation and consideration of the needs of both the home and fighting fronts.

This action of the Committee will lead to review of the home-front medical staff economy. We shall have to make certain that every qualified man is utilised, including refugee doctors. It will also mean that more house-jobs will have to be filled by student house-men in hospitals removed from the Sector.

Finally, it is only just that in war when honours fall upon quick and valiant action of the field that we should pay tribute to the ceaseless, unremitting labour of the doctors at home who have toiled so nobly in the face of countless physical and spiritual setbacks to achieve so fine a result.

All will join in congratulating the Rugby XV on the fine showing against the London Rugby Union. An account appears in this issue. We regret that a photograph of the team could not be printed in this issue, but hope to do so in the next.

The Functions of a Specialist

By FRANK W. LAW, M.D., F.R.C.S.,
Ophthalmic Surgeon to Guy's Hospital.

A Lecture delivered at Guy's Hospital Medical School on Monday, 15th November, 1943.

GENTLEMEN,—I thought to-day that one might introduce a new line and that I might try to interest you in what I conceive to be the functions of the specialist. The title of the lecture may have seemed rather strange to you, seeing that it comes in a series of so-called clinical lectures, but it has its application, and I hope the justification for including such a title in a list of clinical lectures may be found in the illustrative clinical examples which I shall bring forward in making some of my points.

It is as well always when considering a subject to begin with a definition, and therefore one should attempt to define to our mutual satisfaction the terms "consultant" and "specialist." They are often used, incorrectly, as though "consultant" and "specialist" were synonymous. The consultant has been described as the man whose opinion is sought by his peers. That is not an entirely satisfactory definition. We all know something of what a specialist means, but especially in these Beveridge days it is becoming more necessary to have a watertight definition of such terms. The consultant is the man, strictly speaking, who exercises his clinical skill in a consultative capacity by seeing cases referred to him by his colleagues, presumably general practitioners. But that does not hold in every branch. I do not think it is true to say that the consultant would refuse to see a patient who decided to go and see him on the recommendation of a neighbour, or possibly on a knowledge gained from his individual reputation, the prospective patient having read of him in the local library or the "Medical Directory," or perhaps in the gossip column of a newspaper!

On these lines we can decide and agree as to what a consultant is. A specialist is of necessity a consultant who concerns himself with conditions relegated—I do not mean to be derogatory—to special departments of hospitals, such as the ophthalmologist, the oto-rhino-laryngologist, the dermatologist, and so on.

Let us consider for a moment the dangers of specialism, which are very real. The obvious danger, which hardly needs pointing out, is that a man by giving his whole time to a relatively narrow specialty, to the consideration of one organ or group of organs, or one system of the human body, should develop a one-track mind, and neglect the consideration of the rest of the patient. It has been my constant endeavour to avoid that pitfall and, more particularly, to make sure that the students who are kind enough to listen to me shall not think that anybody who enters the eye department must have an eye disease.

I think it is safe to say that that danger is less present in the case of the ophthalmologist than in the case of other specialists, the connections of ophthalmology being so manifold. I think it is commonly agreed that ophthalmology, apart from being one of the oldest specialties, is certainly one of the most justifiable and justified. The most obvious connection of ophthalmology is with neurology. One could not get very far in the study of ophthalmology without the exercise of neurological knowledge; or, let us go further, and perhaps be a little more generous, and say without the assistance of the neurologist. Similarly, the ocular adnexa, as exemplified by the eyelids, interest the dermatologist and, the lids having an inner lining of mucous membrane, they come into the province of the specialist who deals with mucous membrane disorders, avitaminosis, and the like.

This little thesis of mine can be exemplified very well anatomically. If one thinks of the orbit one has only in imagination to go forward to come into the territory of the dermatologist; to go backwards or upwards into the cranial cavity, to be in the territory of the neurologist and cranial surgeon, and to go inwards or downwards to be in that of the ear, nose and throat surgeon.

To consider some of the functions of the specialist: there are very likely others of which I have not thought, but taking naturally, perhaps egotistically, the example of my own specialty, the first and most obvious function is to be of help to the student, patient, and colleague in his own line of country. It is, I think, evident that no general student or practitioner of medicine can hope to have sufficient knowledge, in these

days more particularly, of a specialty as not only to practise it adequately, but to teach it successfully. That, of course, is a relatively recent development. It might interest you, taking as an example our own hospital, to know how long ophthalmology or ophthalmic surgery, as it was more frequently known in the earlier days—a nice difference but an important one—has been regarded as a specialty. Previously, of course, it was in the hands of the general surgeon as regards surgery, and the practice of ophthalmology as an academic art was in its infancy. There are now two ophthalmic surgeons to this hospital, of whom I am one. We had two predecessors, one of whom is now President of the General Medical Council, and the other is very nobly carrying on, after having retired, in a Sector hospital. There were two others before them, and before those earlier two there was one other—and he was the first. So that it is not very long since ophthalmology first came to be regarded by Guy's Hospital as a justifiable specialty. The Ophthalmological Society of the United Kingdom was founded by Sir William Bowman in 1880, which is not very long ago.

Far be it from me to hint that the astute experienced general practitioner is not competent to deal with a large proportion of the eye cases which come under his care. But, in teaching, the broad outlook which must come to the man who does give his whole time to one region should make it easier for such a man to teach the essentials and details of his specialty to a student, rather than the man who sees an eye case as an incidental one in a string of other patients.

The second function of the specialist—I am just giving these as they occur to me—is to guard against the one chance in many. As an example of that I ask you to consider with me the possibilities of our old friend, the corneal foreign body. What is the possible outcome of the reception of a foreign body on the cornea? The answer, as you know, is anything from nothing at all to the loss of the eye. The ordinary treatment of a corneal foreign body, which we will consider superficially for a moment, is obviously enough for the vast majority of cases, but the one in a thousand may turn and rend you. The specialist should be in a position to exercise his increased experience in order to save that one case from disaster.

The superficial corneal foreign body under good illumination, with proper magnification and a steady hand, may be removed with the minimum of damage to the corneal epithelium. Indeed, no staining with fluorescin may result after the removal of a very superficial corneal foreign body. The more deeply embedded one needs removal, preferably with a Bowman needle, and there is inevitably a loss of a few epithelial cells. These, however, regenerate in a matter of hours with proper treatment, and that is the end of the story, though it is potentially more serious than the previous one where no abrasion followed removal.

Then there may be a foreign body lying more deeply, the removal of which results in damage to Bowman's membrane—that, by the way, is the third time in this lecture that I have mentioned the great Bowman. This may entail damage of, or at any rate, intrusion into, the substantia propria of the cornea.

I need not talk about intra-ocular or penetrating foreign bodies, but let us now consider a third type of foreign body case, allowing in the conjunctival sac certain unsuspected and hitherto harmless lodgers—a small family of pneumococci, a little colony of streptococci, or *Staphylococcus aureus*, all of them looking for a nice comfortable situation in which to settle down and breed. When that happens an infected abrasion immediately results, but with proper and adequate treatment nothing more may occur. Sometimes, however, a corneal ulcer will result, and according to the depth of the corneal ulcer, the resistance of the globe and the severity of the infection, the outcome may be good or bad. If bad, a reactionary iritis may be set up, with exudate and cells—leucocytes—in the anterior chamber, forming a hypopyon. The infection may not respond to treatment. The whole eye may be inflamed and endophthalmitis may be set up, resulting in loss of the eye. Please do not take away the impression that such a sequence of events is common, but it is always possible. I do not want you to get the impression that when you see a superficial corneal foreign body you should treat it as though the grim sequence which I have outlined must occur.

The routine instillation of a mydriatic, which is also a cycloplegic, may result in putting a working patient off work for many days by reason of paralysis of his ciliary muscle, whereas he could have been back at work in a matter of hours without such instillation. On the other hand, if this sequence of events is likely to occur the early instillation of atropin may make a material difference to the eventual outcome.

Now, how can a man who is only occasionally seeing an eye case do other than call in his ophthalmological colleague when he suspects things are going the wrong way? Alternatively, he may treat every case as though it were on the way to disaster, which would be a very uneconomic thing to do.

That simple example, I hope, will justify my second suggestion as to the function of a specialist, that of guarding against the one chance among many. The third function of the specialist is to assist—not necessarily to take over from—the general practitioner in the diagnosis and treatment of a case. Here, as a further example justifying the inclusion of this talk as a clinical lecture, let us consider the case of herpes zoster of the fifth cranial nerve—an interesting, rather frequent condition which can often be diagnosed, so to speak, before it is there, by a description of the subjective symptoms of the patient. Herpes zoster of the first, or possibly the first and second divisions of the trigeminal nerve must affect the eye to a greater or lesser extent, and what might happen is comparable to what I have just described as being possible in the case of corneal foreign bodies. It is not for me to speak of trophic nerves or impulses. First of all, it is not quite my line of country and, secondly, it is rather *démodé* in these days, but one can at least agree that the nervous supply to a part has a fundamental effect on the capabilities of the part in its reaction to trauma.

The immediate possibilities of an attack of herpes zoster are many. There may be corneal loss of lustre, of surface, of transparency, a conjunctivitis, an iritis, a glaucoma. A retro-bulbar neuritis may result from the herpes; and loss of corneal sensitivity is an invariable almost sequel of ophthalmic herpes. Thus one is continually up against the possibility of trauma, however minute, to an insensitive cornea, which may not be appreciated by the patient nor resented by the tissues—I mean that the tissues may not be in a condition to resist such trauma as one would like them to resist. Thus a series of events, including corneal ulceration, infection, and so on, may result in an otherwise negligible trauma as a result of ophthalmic herpes and its consequent anæsthesia.

Very well, the general practitioner has a case of painful herpetic eruption on the brow, the side of the nose and one side of the scalp. He knows what might happen. He can treat the herpes perfectly well, but he gets worried when he looks at the eye. He notes that it is red and rather watery, as it usually is in such cases. But there comes a day, quite early on perhaps, when the cornea looks rather hazy; there may be some loss of surface, though a corneal abrasion cannot be seen. There the ophthalmologist perhaps can come in, not to take away the case, but to advise upon the appropriate treatment of the condition and to warn as to the danger-signs to be looked for as the case proceeds. In some cases the expedient of tarsorrhaphy (or suture of the lids over the cornea) may be the only way of saving the eye. Again, to draw a parallel between this and the foreign body, the general practitioner might avoid the possibility of damage to the eye by a routine tarsorrhaphy as soon as the herpes occurs. To do this would be uneconomical and usually unnecessary.

The fourth function of the specialist is to collaborate with other specialists and consultants. That, I think, I need not expound very considerably. We have glanced at that as we have gone along. The neurologist is the man who most clearly and obviously links up with the ophthalmic specialist in a collaborative consultative capacity.

The fifth function is to acquire and to disseminate knowledge which is of use to the general practitioner of medicine and hence to mankind in general. Clinical research is obviously the province of the clinician, laboratory research of the laboratory worker. But no laboratory worker, I think, would submit that his knowledge of clinical and other problems in the region of the eye was sufficient to enable him independently to undertake reasearch in that direction. It may be said with some justification that the aid of the special pathologist in the eye department is necessary; also that the collaboration of a biochemist is essential. It is surely in that latter direction that the most useful field for future ophthalmic reaserch presents itself. But in that collaboration the guidance and assistance of the clinical specialist is desirable, for it is too much to hope that all the clinical and biochemical knowledge can be embodied in one person.

The last function of the specialist to which I want to allude, but one not restricted to him, is that of teaching his specialty. It is my opinion, for what it is worth, that the specialist should—if not must—be on the staff of his special hospital, for only there does he see a sufficient turn-over of cases to keep himself thoroughly knowledgeable with regard to all the developments. There also he has at his elbow colleagues,

specialists like himself, with whom he can consult or discuss difficulties or new conditions. I do not think there is any doubt, granted that a hospital appointment is desirable, that there is anything to compare with an appointment on the staff of a teaching hospital, both for its interest and for keeping oneself thoroughly alive in one's own particular field.

It is the specialist's function to correlate his specialty with other branches of medicine and surgery in the student's mind, and to prevent what he has always been guarding against in himself, a narrow outlook in those he teaches.

May I give you as a clinical example of this argument the question of squint in ear disease ? A small patient is admitted to a hospital with a diagnosis of acute middle ear disease. The observant dresser comes along, takes all the history he can, either from the child or the parents, and in the course of routine examination notices that the child is " boss-eyed "—to put it in its lowest specialist terminology ! That may be very important or may not be important at all. He asks the parents and they say that they do not think they have noticed that the child had a squint, but one cannot be sure. The child may have a convergent squint of the ordinary or concomitant variety and may happen to pick up an acute middle ear disease ; there is no law against that and it may well happen. But, on the other hand, this acute middle ear disease may have caused a spread of infection to the temporal bone in its petrous part, running up to the apex of the petrous bone to the point where this articulates with the sphenoid. At that temporo-sphenoidal articulation there is a ligament, and arching over that is the sixth cranial nerve. If the condition occurred in that way it might well be due to partial or complete paralysis of the sixth nerve on one side preventing abduction as a result of the spread of infection from an acute middle ear disease.

That opens up dire possibilities. The only way of finding out is not necessarily to call in the specialist, but merely to remember certain elementary things. Is the child suffering, in other words, from a concomitant or paralytic squint ? If the eye will not in any circumstances abduct it is likely, though not entirely certain, that a paralytic squint is present. If, on the other hand, the eyes, whatever the direction of gaze, though never straight, maintain a constant angle of convergence between them, and abduction in the affected eye is possible, then one may safely assume that the child possessed a concomitant squint before the middle ear disease developed, and there is no need to assume the alarming spread of infection such as I have just detailed.

May I just add a few words of advice as to your attitude towards your special departments. I think my colleagues, whom I have not consulted, would allow me to say this, but if not, then let me say it for my own department. Special appointments in the curriculum, I think, receive rather scant respect at the hands of those who control it, but I suppose that is inevitable, most certainly in these days. But one must not in a special department assume that the patient who comes complaining of certain symptoms has a condition which is necessarily referable to that department. There is a very much more likely possibility of mistake than one would tend to make in a general department. It is not at all necessary that a patient who enters the eye department should be suffering from eye disease. A patient in acute pain, rolling on the ground in agony, and vomiting, has before now been operated on for an abdominal condition when the cause of all the symptoms was an acutely glaucomatous eye. Many come to the eye department complaining of headaches, but not all of them by any means are necessarily suffering from a refractive error. Note the term " suffering from " ; I do not say " possess," for it is difficult to find a patient in whom one cannot contrive to find at least one-fourth of a diopter of ametropia. I think, indeed, it is true to say that the true headache (as opposed to eye strain) is never due to refractive error.

A case of inflammation of the lid may be only a local manifestation, and, in fact, some general condition, possibly well known to the dermatologist, may be at the back of the trouble. This mental attitude towards your cases must be preserved in all your investigations of cases in the special department. Let us say that you notice in a patient (having, of course, carefully examined him with the loupe and lens first !) some presumably acute or active state of affairs in the fundus which may puzzle you. It is essential to get information about the blood pressure and the chemical analysis of the urine, which may well assist in finally diagnosing the condition. Again, opacities of the lens may be a local manifestation of a general condition for which interference is indicated—I need hardly mention to you the possibility of diabetic cataract. There are other conditions, such as dystrophia myotonica, a rare obscure neurological condition characterised by inability to relax the grip and also almost invariably by the

coexistence of lens opacities. Again, a child is brought to the eye out-patient department and found to be considerably defective visually, and the reason is found to be bilateral dislocation of the lens. That is interesting enough in itself to call for further examination. We then recognise that the patient, with tall, spare, rather gaunt physique, and long, thin, spidery fingers, presents the condition known as arachnodactyly —a condition of obscure pathology which is characterised in a mysterious fashion by bilateral dislocation of the lens. It is the long thin spidery fingers which have given the condition its name of arachnodactyly.

Well, gentlemen, I hope this rather disjointed talk may assist you to adopt a broader outlook in this relatively narrow field, though I also hope that the field may not seem to you quite so narrow as you had supposed. Let me urge you to see the patient and not the disease; to consider and to examine him as a whole rather than only that portion of his body which he offers to you, perhaps mistakenly, for your inspection; let your interest be primarily in the organism and not in the organ.

Treatment of Tuberculous Pleurisy with Effusion

By J. J. CONYBEARE, D.M., F.R.C.P.

1. It may be assumed that all cases of pleurisy with a clear lymphatic effusion are tuberculous, unless there is evidence that they are due to other causes.

2. A large number of patients with tuberculous effusions are found to have been treated with sulphonamides in the earlier part of their illness. This treatment has usually been given under the impression that the patient had pneumonia, but many instances have been noted when administration of sulphonamide has been continued when obvious signs of fluid were present or even after fluid had been aspirated. The sulphonamide drugs are not only useless, but definitely harmful in such cases and the slipshod practice of prescribing sulphonamides in any and every pyrexial condition cannot be too severely condemned.

3. Whenever a pleural effusion is suspected on clinical or radiological grounds an exploratory puncture should be performed with a local anæsthetic infiltrated well down to the pleura and under strict aseptic precautions. 10 to 20 c.c.'s of fluid should be withdrawn and sent for cytological examination and cultivation of organisms, including tubercle bacilli. A total leucocyte count, differential count and a blood sedimentation rate should be done. Further exploratory punctures may be necessary if leucocytosis or other features suggest that the septic infection may be developing.

4. Too often large amounts of fluid are aspirated—sometimes even two pints or more. This procedure is both unnecessary and dangerous.

The only indications for withdrawal of more than a few c.c. for diagnostic purposes are as follows:—

(*a*) Respiratory distress at rest.

(*b*) Marked displacement of heart and mediastinum confirmed by X-ray.

(*c*) Failure of an effusion to show evidence of decreasing in amount after a month of rest in bed.

5. Whatever the indications for aspiration under no circumstances should more than 15 oz. be aspirated at one time. The withdrawal of fluid should be done slowly, taking at least half an hour for 15 oz. Aspiration should not be repeated until at least a week has elapsed, unless rapid reaccumulation of fluid produces distress.

6. Air replacement of a tuberculous pleural effusion is only indicated when there is definite evidence of gross tuberculous disease in the lung, as shown by X-ray or the presence of tubercle bacilli in the sputum. Much damage can be done by overfilling with air, and it is felt that this treatment should be carried out only by those with special experience in chest diseases.

7. All cases of tuberculous pleurisy with effusion, however mild their constitutional symptoms, should be treated in a hospital with full nursing facilities. Complete rest in bed should be enforced for a minimum of six weeks even in the mildest cases. Another six weeks should be spent in hospital. Needless to say, the duration of treatment in

hospital will depend on the severity and persistance of pyrexia and other symptoms and the speed with which the effusion is absorbed. Few cases should return to work, even sedentary, in less than six months. It is important that during the twelve weeks' stay in hospital the patient should be X-rayed at not less than fortnightly intervals. The lung should not be allowed to re-expand completely until it is certain that there is no underlying tuberculous focus in the parenchyma. Experience has shown that tuberculous effusions can absorb very rapidly. The important X-ray is the one when the lung is about three-quarters re-expanded. It should then be possible to see whether there is any disease in the parenchyma and, if this is present, air replacement should be carried out and an artificial pneumothorax established. If no disease is apparent in the parenchyma the fluid should be allowed to go on absorbing normally.

8. The decision as to whether patients who have been hospitalised for tuberculous pleural effusion should complete their convalescence at home or in an institution depends mainly on the conditions in individual cases. In the majority of cases transfer from hospital to a convalescent institution or a sanatorium is advisable for a period of some months. This has the advantage of ensuring that adequate supervision is available, as regards X-rays of chest, blood sedimentation rates at intervals, and graduation of exercise. In some cases, however, when the patient has a good home, particularly in the country, it may be justifiable to allow convalescence at home.

9. It has been found that many patients, who have suffered from tuberculous pleurisy, subsequently develop other tuberculous conditions, chiefly pulmonary. These are often insidious in their onset and may be entirely asymptomatic. It is, therefore, important that every patient should have a routine X-ray of the chest done at three-monthly intervals for at least three years from the onset of their pleurisy. Such X-rays should preferably be done at the same hospital or chest centre, in order that previous films may be available for comparison. It is only by such careful supervision that the development of pulmonary tuberculosis in its earliest stages can be detected and adequately treated.

10. A routine examination of the urine at three-monthly intervals, including a microscopical examination, should also be performed in order to detect early evidence of a tuberculous kidney. Needless to say, any urinary symptoms, such as frequency, should be viewed with the gravest suspicion and such cases should be promptly and thoroughly investigated.

Letter from "Sinbad"

MY DEAR BILL,—So you are coming into this regiment. I've been in just under a year now and there may be a few things which will help you, but remember I've only been in one sort of ship, an old destroyer, so if you get posted to something large and new drop my letter neatly in the waste-paper basket. Once it is settled that you are going in get on leave for a little while to attend to your own affairs ; it may sound good to work up to the last moment, but it is stupid. In my case I was on board ship within three weeks of joining the Navy ; we didn't go to sea for a fortnight, but we might have done so. Take a holiday and visit your friends ; you may not be passing that way again for some time. There is seldom embarkation leave in the Navy, and once you've left port whatever your nominal destination you may end up almost anywhere. It is one of the hardest things to appreciate ; only the other day a friend supposedly on his way home to England was switched with the ship to a distant station for a year or more. During your holiday it is as well to order your uniform ; it is a mistake to wait until you are in barracks to do this. You will be given £55 allowance, which can be allotted to your tailor of choice or paid into your bank. You need two suits, a greatcoat and a cap, two or three shirts, half-a-dozen collars and black tie ; everything else can be bought at the Naval Clothing Stores or "slop shops," whose goods are very cheap and reliable. Start with a minimum amount of clothing ; it will soon accumulate ; but it is wise to carry at least one suit of plain clothes at sea so that you may go ashore in a neutral country. A kapok life-saving waistcoat, with a zip fastener front and capacious pockets, is much more convenient than the regulation rubber tyre type of life-belt. These can be bought from Messrs. Grieve or Mr. Cooper, of Beak Street, and cost about £4. The large pockets will take a syringe, a bottle of morphine sulphate and one's valuables ; apart from its life-saving qualities the jacket is warm and comfortable.

You will be posted to one of the three Royal Naval Barracks, and usually a travel warrant will be sent you. Travelling on duty is paid by the Admiralty, but you must send in an accurate account of your expenses on the correct form. A barrack, even after a "blitz," is an imposing place, and while you are still wearing plain clothes you will feel strange among grizzled and medalled officers whose arms are thickly arrayed with gold lace. The odd habit of calling the floor the deck; ceiling, the deck heads; beds, bunks; walls, bulk heads is confusing at first, but in a week you will catch yourself doing the same thing. Don't adopt the vocabulary too readily; it is much easier to talk naval jargon than to be a sailor, and you can make yourself singularly ridiculous by an over-enthusiastic wedding to the sea on dry land.

Your training will consist of a divisional officer's course lasting fourteen days and a certain amount of instruction in medical forms, lasting anything from a few days to a few weeks. The divisional course is one for all newly appointed officers; I was the only doctor in a class of fifty to sixty. My companions had been in every sort of ship and provided me with a great deal of information and advice. Since most of them had just been promoted from the lower deck this was particularly valuable to me. I lived in comfort for 1*s.* 2*d.* a day, spending the morning marching about on the square and hearing about the Navy and its ways. It was not onerous and I enjoyed it greatly. I left at the end of a fortnight, summoned at four hours' notice to a northern port where an old V. and W. destroyer was waiting for me. I imagined that she would be standing by with steam raised from the urgency of my departure. However, I had nearly three weeks to make preparations and this respite was welcome.

Early in your service career you will be asked how you want your money; the Naval accountant system is said to be foolproof, and this I believe, but it always seems one of the black arts to me. You may take your pay in cash or have it paid by cheque into your bank as a monthly or quarterly allotment; this has the advantage that the money continues to be paid for some time should you be posted "Missing" or "Prisoner of War." Its disadvantage is that you never have the pleasure of receiving £40 or £50 in notes at the end of a trip, which gives one the sensation of Dr. Johnson's wealth beyond the dreams of avarice.

Once you have discovered your cabin, seen your fellow officers and accepted the proferred gin or cup of tea, depending upon the time of day, you should ask a kindly sub-lieutenant to show you round the ship, not that you'll remember much, but he will tell you the names of the other officers again. The engineer officer is always "Chief," the gunner always "Guns," the first lieutenant "Number One," but even these recognised anonymities prefer that you should know their real names. You, by the way, will be "Doc," and if another one is present it is Doc. X and Doc. Y, where X = H.M.S. X, Y = H.M.S. Y.

The next big moment is meeting your Sick Berth Attendant, as he will be your companion for much of the time during the ensuing months; he is an important person. You are unlikely to get a regular S.B.A.; he will probably be "hostilities only." Both mine have been fairly experienced, hard-working and willing fellows, but yours may well be very ignorant and have had only a few months' training. Do not be surprised if he has no ideas of asepsis, commits the horrid crime of squeezing boils and has heroic rather than conservative ideas about medicine.

Early on you must get some idea of the layout of the dockyard in your immediate vicinity; these places are a litter of railway lines, cranes, old iron, acetylene welders, sheer drops of many feet and a variety of pitfalls. Don't go out at nights without a torch.

Well, I've got you to your ship; dazed, pleasantly somnolent with the fatigue of your journey and, after a glass or two of port, you are about to retire to your bunk. The world is rosy except for such minor matters as the lack of a steriliser, the non-arrival of your medical stores; the fact that you nearly fell down the ammunition hatch outside your cabin and broke your leg; that you cannot remember which of those two angular young men is the first lieutenant and which is the navigator; that you don't know where to get a wash and there is no hot water in your cabin—but don't let it worry you, Bill, worse things happen at sea, much worse.

Your peripatetic Pen-pal,

"SINBAD"

(because everyone knows I'm not a sailor).

Guy's Rugby Centenary Match

GUY'S *v.* LONDON RUGBY UNION.

(*Played at Honor Oak Park on November 27th,* 1943.)

Lost by 1 goal to nothing.

THE London Rugby Union honoured Guy's by fielding a strong side for the Centenary match on November 27th. The day did little to encourage spectators, yet they came in numbers reminiscent of pre-war Cup matches. Some had been invited, some just turned up, but together they formed an inspiring body of Rugby personalities. We gather they were not disappointed and the teams rose well to the occasion on a ground which at least could boast to be a "typical Guy's pitch."

Guy's won the toss and elected to defend the far end. London attacked hard from the kick-off, but made little headway against a solid and vigorous defence. The backing-up of the forwards was particularly good, and although London had more of the play they never looked like scoring.

The play constantly changed from end to end once Guy's settled down, and the backs handled the slippery ball with great skill, but could gain little ground. On two occasions London were penalised in their own "25," but the kicks at goal both failed.

In the second half we began in great style and were in the London half for most of the first quarter of an hour. The pack, who played a grand game all through, had much the better of their encounters and the ball came back with regularity. On one occasion a forward rush resulted in Brittain dribbling the ball over the line, but he was just beaten to the touch-down.

Strathie played an invaluable game and Graham, whose handling was particularly good, twice cut cleanly through to be pulled down before he reached the line. Although we sustained the pressure London would not be broken down, but fought back well, so that the game took on its former aspect. Jackson got by Boyd just once, but was pulled down by Hildick-Smith, who had played a very sound game at full-back in the most trying conditions. A set scrum was given almost on our line, and Parsons got over for the only score of the match, the try being converted by Hall—and the final whistle blew. So Guy's were beaten at the last moment, but only after an exhibition of football which did justice to the most sparkling days in their history. The try was best summed up by Wing-Commander Gadney, refereeing the match, who thought at the time (and confessed to it at supper afterwards): "Yes, it's a try all right, but you don't —— well deserve it."

Teams.—Guy's: G. Hildick-Smith (Haileybury); A. C. Macrae-Gibson (St. Dunstan's), N. K. Macrae-Gibson (St. Dunstan's), D. M. Strathie (Rugby and Oxford University), D. C. Boyd (Durban, Natal); E. W. Graham (Whitgift), R. D. Willcock (Ellesmere); R. G. L. Brittain (Oundle) C. Vidot (Alexandria), P. D. Harvey (Marlborough), C. Ziervogel (Capetown, Western Province), D. L. Gullick (Taunton), A. Batty Shaw (Rugby and Oxford University), A. B. Lee (captain) (City of London), R. A. Dean (Bishop's Stortford).

London Rugby Union: M. C. Morgan (Wasps); A. L. Warr (Richmond and England), P. I. Rutherford (King's College Hospital), P. H. Waterkeyn (Rosslyn Park), T. G. H. Jackson (Rosslyn Park); J. Parsons (Leicester, R.A.F. and Wasps), N. M. Hall (St. Mary's Hospital); R. A. P. Hogbin (Old Paulines), N. Compton (Wasps) (captain), D. J. O'Brien (Wasps), G. W. Lamb (Rosslyn Park), J. R. C. Matthews (Rosslyn Park), R. E. Prescott (Harlequins and England), H. C. Clarry (Wasps), J. A. Dew (London Hospital and Cambridge University).

Referee.—Wing Commander C. Gadney.

Centenary Celebrations

GUY'S Hospital Rugby Football Club is the oldest in existence, with the exception of Rugby School, where the game started. The hundredth season was celebrated at Honor Oak Park on Saturday, November 27th, with a match between Guy's and the London Rugby Union, which is reported above.

For some time before the kick-off Rugby Union officials, County officials, Past Captains of Guy's, many of the Hospital's distinguished players from the 'eighties and several members of the Staff congregated together in the pavilion. As they entered

the ground one noticed our Superintendent, Professor T. B. Johnston, in company with Air-Commodore J. J. Conybeare, Mr. W. D. Doherty and Mr. C. S. Lane-Roberts. Two of the oldest past captains in Dr. A. A. Allport and Dr. K. B. Alexander (they were accompanied by Paul Alexander) were particularly noticeable, and later were joined by T. Morgan and J. R. F. Popplewell. No Rugger gathering is complete without Dr. E. ("Teddy") Morgan, and there he was surrounded by old friends, not the least of whom was Colonel S. McK. Saunders. Mr. H. Millett was another notable figure; Dr. A. Alcock, now President of Gloucester, talked to Tom Voyce, Dr. R. E. Williams (hon. secretary during Mr. Doherty's years as captain), A. D. Stoop, Mr. A. J. Trollope, Mr. H. E. B. Wilkins, and many others too numerous to mention.

The centenary supper was appropriately held in the Pavilion at Honor Oak Park, but this was preceded by a gathering of friends doing justice to an excellent tea and exchanging reminiscences. The arrangements had been carefully planned, and every credit is due to the organisers for its perfection. As if by magic, tea was cleared away, the guests adjourned to the dressing rooms, where refreshment was provided, and punctually at 6.15 p.m., the scheduled time, over eighty sat down to the supper presided over by Mr. W. D. Doherty, the President.

Following an excellent meal, which amazed everybody by its quality and rapid service, the President rose to toast the King. Then Mr. H. E. B. Wilkins, President of Kent County R.U., surprised us when he proposed the toast "Guy's Hospital R.F.C." with a sound knowledge of Guy's past history which took him back as far as 1870. Mr. Alan Lee, the present captain, responded with wit and humour in describing the exploits of some of the great players of the past, especially of W. G. Mitchell in turning up on occasions without togs, and at another time in running the wrong way with the ball. He also paid tribute to the work of Mr. King Rist and to Messrs. John and George Winston for their effort on behalf of the club.

The President paid great tribute to the honoured guests. He mentioned the fine work of the Rugby Union, with which he coupled the name of Colonel J. ("Jock") Hartley; also the London Rugby Union, and Mr. Nevelle Compton, the captain that day; the London Society of Referees; and the name of Mr. A. J. Trollope and Wing-Commander Cyril Gadney, who had refereed the centenary match. The internationals present came in for high praise, especially those sitting at the tables—namely, Dr. A. A. Allport, Mr. A. D. Stoop, Dr. Teddy Morgan, Captain Robin Prescott and Mr. Tom Voyce. Finally, Mr. Doherty spoke of the great part that the Dominions had played in the history of Guy's Rugger, placing particular emphasis on the New Zealand influence between 1902 and 1909, and the wonderful play of the South African contingent in 1919 and the years that followed. Others to receive recognition were the United Hospitals, with Mr. H. Millett (Hon. Treasurer), Mr. Cecil Dixon (President of Rosslyn Park), Mr. W. C. Ramsay (of the Middlesex Rugby Union), and Dr. A. Alcock (President of Gloucester), and, lastly, the Press.

In replying, Colonel Jock Hartley urged the club—and, indeed, all Rugger clubs—to prepare for post-War reconstruction, as he was convinced sport would play a greater part in the lives of the people than ever before. Mr. Nevelle Compton said that it had been an exceedingly good game and that Guy's were unlucky to lose. Mr. Trollope told us that Mrs. Trollope should receive the credit of his fixture exchange; and as regards the referees we were reminded that there was no such thing in 1843. Wing-Commander Gadney seemed thorougly pleased with the game, in which he maintained Guy's did not deserve to lose.

Dr. A. A. Allport evaded a speech on the grounds that Alan Lee had "stolen his copy," but, indeed, was nearly inveigled into giving a song, and might have done had he not left his music at home. Mr. A. D. Stoop said a few words, and was followed by Dr. Teddy Morgan, amidst loud applause, who said how proud he was to be present on such an historic occasion and, most of all, how proud he was to be a Guy's man. He advised the players to continue playing the game as they had done that afternoon, and nothing could go wrong with Guy's Rugger. Captain Robin Prescott introduced his usual humour and told us that a remarkable change had come about in war-time, in that international captains got together and said: "Let's have a good open game for the public," and he hoped that spirit would continue after the War. The speech of the evening came from Mr. Tom Voyce, who cast sly winks at our President when speaking of the tussles they had had together, but included a touch of sentiment when he said he considered Guy's the team of the country; that he had always followed

their fortunes; and that his son was named Guy. He caused much laughter when expecting to see any moment a bearded old gentleman spring from one of the corners and say, "I remember playing for Guy's in 1843," but the shadows of the past were quite definitely surrounding that distinguished gathering.

Dr. K. B. Alexander replied for the Dominions, and was followed by Colonel S. McK. Saunders. Mr. H. Millett pointed out the excellent spirit of friendship existing between the hospitals and the fine club games they were now having amongst themselves. Mr. Cecil Dixon responded for Rosslyn Park and the London Clubs, and was followed by some reminiscences from Dr. A. Alcock; from him we discovered that England might never have heard of Tom Voyce had it not been for a timely operation many years ago. Finally, Mr. P. Rudd, Past President of the Press Club, replied for his colleagues.

This athering will be for ever memorable in the hearts of all present, but an account would not be complete without according a very hearty vote of thanks to Mr. John Winston and Mr. A. Batty-Shaw for their excellent organisation, and to Mr. Kirby, the groundmen, Mrs. Kirby and their friends for the most able and efficient manner in which they provided for the guests, thereby so largely contributing to the success of the evening. G. W.

Farnborough Letter

WITH Winter has come a few changes in house appointments, a boom in social activities, and, of course, that hasty cycle sprint past the police-station without a back lamp.

Henderson and Wilshere have left for other appointments in the Sector. We welcome McCallum and Laws in their place.

The change of season has produced a burst of activity from the Social Committee of the County Hospital. It is organising a dance a month and various shows. We have had so far two very successful dances and two shows—"The Twerps" and a N.F.S. troupe, which, I'm told, resembled the curate's egg in some respects.

A very active dramatic society has been started or reformed, and is drawing talent from all sections of the Hospital. They are play-reading each week and, in the New Year, hope to produce three one-act plays—"Mr. Hachett's Alibi," "The Crimson Coconut" and "The Bathroom Door."

The Physical Society appears to be flourishing. It is holding meetings regularly each month. Good attendances and loose tongues are assured by "free beer."

All signs portend a happy Christmas. E. G. M.

Sport

Hockey

GUY'S *v.* ST. MARY'S.

(*Played at Teddington on November 27th.*)

Lost 2–1.

During the morning the chances of playing this game looked very slight, but St. Mary's insisted that their ground was quite fit, so we went down to Teddington though perhaps would have preferred H.O.P. It turned out to be one of the most enjoyable matches we had had. Guy's had two representatives in the London University side and two more of the team away for other reasons. We were without a goalkeeper and played a "kicking back" instead. The teams were very evenly matched, but owing to this extra player in the backs Guy's apparently pressed most of the time during the first half. At half-time St. Mary's led 1–0 and increased their lead early in the second. Burt scored for Guy's shortly after this, and for the last ten minutes Guy's tried desperately hard to equalise but were unsuccessful.

Team.—D. C. Dawson, B. H. Prideaux, H. W. Trusted; K. W. Bolt, J. G. Richards, J. D. Rumble; G. Thompson, C. J. Jenkins, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

Against Cambridge University at Broxbourne on November 20th, Guy's lost 6–1.

On December 4th, *v.* Tulse Hill, at H.O.P., Guy's lost 2–1.

Association

GUY'S *v.* LONDON HOSPITAL.
(Won 6–0.)

This game was played at Chingford on Saturday, November 13th, and resulted in another clear win, by 6 goals to nil. Guy's took the lead from the start and made good use of a slippery ball by quick passing and good control; the forwards, however, did not shoot often enough under the circumstances. At half-time the score was 3–0, the opening goal being scored through R. Owen with a fine angle shot.

During the second half the play was entirely in London's half of the field, and Guy's were rewarded with a final score of 6–0, including one penalty goal.

This match places Guy's at the top of Group "A" in the League.

Team.—N. J. Crane, E. G. Murphy, F. R. M. Young, C. S. Mathews (captain), R. D. Rogers, S. Stableford, R. Owen, R. Finney, C. B. Clarke, M. J. L. Sykes, A. E. Trist.

GUY'S *v.* CHARING CROSS AND R.D.H.
(Won 7–2.)

This game was played at Honor Oak Park on Saturday, November 20th. This match was played in most unfavourable conditions—fog, which was at times very thick, and a slippery ball. However, Guy's played well together and were soon rewarded by a goal through R. Owen. Charing Cross then equalised, but within a minute Guy's took the lead again and at half-time the score was 3–1.

The fog became thicker and during the second half the game became scrappy; however, the forwards made good use of their opportunities and Guy's finally won by a clear margin of 7–2, goals being scored by A. E. Trist, S. Stableford, R. D. Rogers and R. Finney.

Team.—N. J. Crane, R. Macneil, F. R. M. Young, S. Stableford, E. G. Murphy, C. S. Mathews (captain), W. Hall, A. E. Trist, R. Finney, R. D. Rogers, R. Owen.

Hospital Information, etc.

Notices

TEXT-BOOK OF PHARMACOLOGY.

Difficulty is being experienced in obtaining Gaddum's "Pharmacology," and any students who can help by loaning or selling copies of this text-book are asked to inform the Medical School Office as soon as possible.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

November, 1943.

Pathology, Bacteriology and Forensic Medicine.—P. L. Brangwin, D. E. M. Brown.

Medicine.—D. E. M. Brown, D. A. Tait.

Midwifery.—*C. M. F. Fiducia.

* Has completed the examination.

Appointments

Dr. Hugh Franklin has been appointed Anæsthetist to the Gloucester City General Hospital E.M.S. Plastic Surgery, Burns and Jaw Injury Unit; also Honorary Anæsthetist to the Gloucestershire Royal Infirmary.

Colonel J. B. Hance, C.I.E., O.B.E., V.H.S., I.M.S., has been appointed Honorary Surgeon to the King.

Papers by Guy's Men

Hurst, Sir Arthur. Some medical aphorisms. *Clin. J.*, 1943, **72**, 211.

Macintosh, R. R., and Another. Intra-arterial injection of Pentothal. *Lancet*, 1943 ii, 571.

Eckhoff, N. L. Burns. *Clin. J.*, 1943, **72**, 213.

Ryle, John A. Social Medicine: Its meaning and its scope. *Brit. Med. J.*, 1943, ii, 633.

Pringle, K. E., and Breakspear, E. K. The Planning of Orthodontic treatment on a National Scale. *Brit. dent. J.*, 1943, **75**, 233.

Stamm, T. T. The diagnosis and treatment of the common causes of pain in the foot. *Post-Grad. Med. J.*, 1943, **19**, 231.

Erskine, David. Venereal Diseases. *Practitioner*, 1943, **51**, 305.

Stamm, T. T. The use of massage in the treatment of joint injuries. *Med. Press*, 1943, **210**, 327.

Crisp, E. J. Massage and Exercises in the after-treatment of fractures. *Med. Press*, 1943, **210**, 329.

Herbert, W. E. Acrylic Resin Restorations and Ether Anæsthesia. *Brit. Dent. J.*, 1943, **75**, 259.

Cushing, R. W. Diphtheria: The "Bull-neck" Hypertoxic Type. A mixed infection. *Jour. R.A.M.C.*, 1943, **81**, 165.

Mentioned in Dispatches

Brigadier E. R. Boland, in recognition of gallant and distinguished services in North Africa.

Deaths

AIR.—On November 28th, 1943, at South Norwood, Samuel Henry Cummings Air, M.B., B.S., L.R.C.P., M.R.C.S., aged sixty-four.

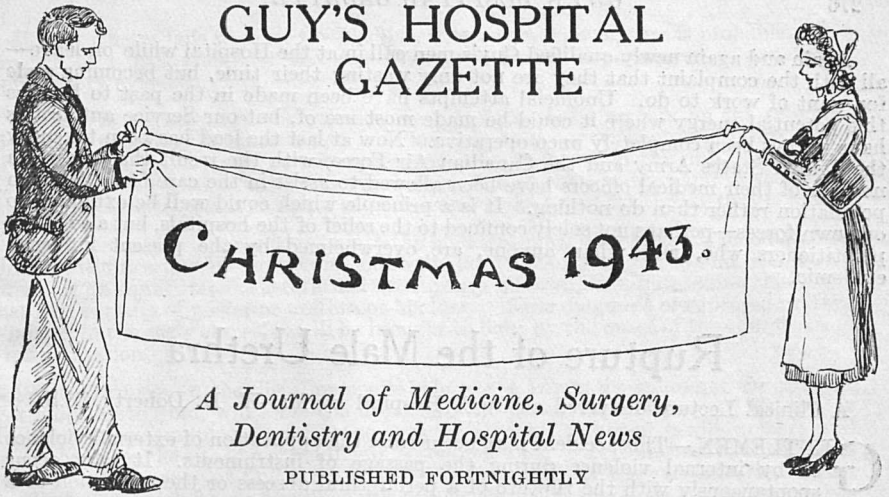
BARTON.—On November 15th, 1943, Theodore B. Barton, L.D.S., R.C.S., in St. Thomas's Hospital.

PITT-PAYNE.—During October, 1943 (on active service overseas), William Stephen Pitt-Payne, Ft.-Lt., R.A.F., aged thirty-seven.

ROBERTSON.—On November 23rd, 1943, at 2, Queen's Road, Worthing, W. I. Robertson, M.D., formerly of Thurlow Park Road, Dulwich.

EDS. { D.R.S.S. / J.P.M.B.

GUY'S HOSPITAL GAZETTE



A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVII. No. 1446 *25th December, 1943* *Ninepence*

PASSIM

BELIEVE it or not it is Christmas Day; this for the benefit of those who have indulged in the popular observation that one would scarcely know it was Christmas. Personally we were aware of it, and at least one abortive Christmas shopping expedition was necessary before we felt capable of saying convincingly that we had tried everywhere. We may assume that it is still early—the *Gazette* being read at breakfast on its day of publication for the first time in years. Not that we for a moment imagine that your *Times*, *Express* or *Chronicle* lie unopened and neglected, but they simply are not there—assuming also that the exigencies of last evening's carol-singing, "etc.," have not wholly discounted breakfast itself. You have verified that for once your initials are correct in the sports accounts, noticed a seasonal cartoon, passed a husky comment to the porridge about "lowering the tone," and now, as "Passim" looks agreeably brief, here you are. It must come somewhere so why not here? We do wish you a very enjoyable Christmas and a prosperous 1944. The setting provides an unrivalled opening for pointing out the lessons of the last twelve months, for making fascinating yet certainly fallacious prophecies of events to come, but with deference to the time of day, the dried eggs and the weather, the impulse must be suppressed and you be allowed to finish your marmalade tranquilly.

IT is a long while now since the first party of United States Army doctors came to see Guy's. Our first sentiment—though we dared not admit it then—was of pride at this recognition. Then an awful suspicion that they could only get a very poor impression from any so brief a visit and would leave convinced that we had nothing "on" their immaculately modern and imposing hospitals at home. But that sense of inadequacy was soon succeeded by a burst of redoubled pride as more and more parties came. Even those who showed them the Hospital became used to this new rôle and, in a surprisingly short space, were able to exchange notes on our history with all but the very best informed visitor. Recently a change has become apparent; single American officers have been seen without escort. They, too, all wear similar fine-rimmed glasses, the same uniform, and have the same relentless passion for gum, so why this apparent lack of hospitality? This similarity merely confirmed our view that all Americans did, indeed, look the same. However, with a stroke verging on genius, someone more astute than ourselves succeeded in resolving these figures into precisely two individuals, and we extend a warm welcome to them as temporary members of the staff. We also welcome the United States Army sisters who have come with them.

Again and again newly-qualified Guy's men call in at the Hospital while on leave—all with the complaint that they are not only wasting their time, but becoming stale for want of work to do. Unofficial attempts have been made in the past to harness this potential energy where it could be made most use of, but our Service authorities have always been completely unco-operative. Now at last the lead has been taken by the United States Army and the Canadian Air Force, with the result that a certain number of their medical officers have been allowed to assist in the care of the civilian population rather than do nothing. It is a principle which could well be extended to our own forces—perhaps not solely confined to the relief of the hospitals, but also of the practitioners who, more than anyone, are overwhelmed by the present influenza epidemic.

Rupture of the Male Urethra

A Clinical Lecture delivered at Guy's Hospital by Mr. W. D. Doherty, M.S.

GENTLEMEN,—This accident may occur from the application of external violence or by internal violence during the passage of instruments. It may occur spontaneously with the rupture of a periurethral abscess or the ulceration of a malignant neoplasm.

ANATOMY.

You will remember that the urethra is divided for purposes of description into three parts and that the middle or membranous portion is very short, ¾ inch, and is simply that portion which lies between the two layers of the triangular ligament (urogenital diaphragm). It is surrounded by a voluntary sphincteric muscle, the compressor urethræ, which thus shuts off the anterior or penile urethra from the posterior or prostatic urethra.

This is an important anatomical fact which has a bearing on our subject, and there is another important one which I must describe to you. The superficial fascia of the penile and scrotal region is divided into two layers, the superficial one being continuous with the superficial fascia of adjacent regions, perineum, abdominal walls and thigh.

The deep layer, however, called the fascia of Colles, is a strong aponeurotic layer which is continuous in front with the dartos of the scrotum, the deep fascia of the penis and the deep layer of the superficial fascia of the abdominal wall (Scarpa's fascia). On either side, however, it is firmly attached to the margins of the rami of the pubis and ischium as far back as the tuberosity and posteriorly it blends with the lower free margin of the triangular ligament (urogenital diaphragm). The importance of this is that there is thus formed a pouch, closed below but open above into the subcutaneous tissue of the abdominal wall which, under certain circumstances, may become full of extravasted urine.

RUPTURES DUE TO EXTERNAL VIOLENCE.

These may be the result of penetrating wounds by stab or gunshot or, more commonly, crush injuries, with which are frequently associated fractures of the bony pelvis. A fall astride some hard object may crush the urethra against the under surface of the symphisis pubis and cause a partial or complete rupture. In this case the damage is likely to be to the membranous urethra or its junction with the penile portion, the bulb.

A more severe injury causing fracture of the rami of the pubis may result in a rupture of the membranous urethra or its junction with the prostatic urethra.

Diagnosis.—The history of a severe perineal injury should always lead one to suspect a rupture of the urethra, and it must be remembered that such violence may produce other severe injuries such as fractured pelvis, ruptured bladder or injuries to the bowel. These may be associated with considerable surgical shock, and hence the injury to the urinary passages may be overlooked until some complication has occurred.

It is unlikely that a rupture of the urethra distal to the voluntary sphincter will occur without some blood appearing at the external meatus. This sign should, therefore, always be looked for and, if it is positive, I would advocate the passage, under the strictest aseptic precaution, of a soft rubber catheter. If this enters the bladder, as evidenced by the drawing off of clear urine, then the injury is a contusion or partial rupture and nothing further need be done as extravasation is very unlikely to occur.

If the catheter fails to enter the bladder, then a complete rupture is probable. The presence of a hæmatoma at the site where the tip of the catheter is arrested is confirmatory evidence.

If there is a fracture of the pelvis with a rupture of the urethra on the proximal side of the voluntary sphincter, and it is unlikely to occur without a fracture of the pelvis, then there may not be the appearance of any blood in the anterior urethra. Hence, in dealing with an injury in which there is a fracture of the rami of the pubis, I think it is wise to pass a catheter as before and make sure that the urethra is intact.

The catheter may appear to pass into the bladder, but if only blood or blood-stained urine is withdrawn, a known volume of sterile liquid should be run in and drained off again. If an equal amount is returned the rupture is incomplete, but, failing this, there must be a rupture of posterior urethra or bladder. If the diagnosis of ruptured urethra be missed in the early stages, it will be brought to light by the onset of the complication of extravasation of urine.

With a rupture on the distal or penile side of the voluntary sphincter the patient, in attempting to void, will force the urine into the periurethral tissues. This area so affected is in communication with the exterior through the open penile urethra and rapidly becomes the site of a spreading infective cellulitis. It is in these circumstances that the attachments of Colles fascia are of importance. If the extravasation occurs into the pouch which I have described, the cellulitis will not, therefore, spread backwards or laterally, but forwards into the tissues of the scrotum and penis, and thence up on to the anterior abdominal wall. If the rupture of the urethra is on the proximal or prostatic side of the voluntary sphincter the patient, in attempting to void, will extravasate into the perivesical tissues and cause a cellulitis in the cave of Retzius. This area is shut off from the exterior by the voluntary sphincter, and hence secondary infection will be a late complication. The condition may be recognised by the appearance of a suprapubic swelling which resembles a distended bladder, but which a catheter fails to drain.

Treatment.—The treatment of a complete rupture of the urethra is operative at the earliest possible moment. The distal urethra is explored through a perineal incision, the ends found and sutured. I prefer to do this around a urethral catheter and to divert the urine for a few days by means of a stab suprapubic drain. Ruptures of the proximal urethra are explored through a suprapubic incision and repaired again around an indwelling catheter with suprapubic drainage. The suprapubic drainage may be dispensed with as soon as the urine is free of blood and the urethral catheter at the end of ten days.

The occurrence of a urethral structure at the site of the injury must be prevented by the passage of an 18/22 F. metal bougie at regular intervals for a period of at least two years.

RUPTURES DUE TO INTERNAL VIOLENCE.

These occur during the injudicious passage of rigid instruments along the urethra, most commonly in the attempt to dilate a urethral stricture with a metal bougie. The accident can be avoided by never using any force with a rigid instrument unless you know that the point of the instrument is engaged in the stricture. If so, gentle pressure will show that the instrument is gripped by the stricture, and there is some resistance to its withdrawal. Even so an inexperienced operator is advised not to use any force with a rigid instrument, and it is much safer for him to confine his manuiplations to soft gum elastic catheters and bougies. If the urethra is perforated by an instrument, the rupture will take place just distal to the stricture and, as these are most common in the bulb, there is likely to be extravasation of urine into the pouch formed by Colles' fascia at the first attempt to micturate. The operator should know when he has ruptured the urethra or "made a false passage," as it is called, by the feel of the instrument and by the rather prufuse bleeding it always causes.

I have seen perforations of the prostatic urethra caused during the attempted passage of a cystoscope. Again, the profuse hæmorrhage and the failure to enter the bladder should cause one to visualise the condition. A finger in the rectum will discover the point of the instrument lying in the rectovesical tissues.

Treatment.—If a rupture of the urethra has been caused during the attempted passage of an instrument, I am sure the best treatment is an immediate suprapubic

drainage. If this is not done and extravasation occurs, suprapubic drainage will become imperative and the toxic absorption from the cellulitis may even prove fatal in an elderly patient.

SPONTANEOUS RUPTURE.

1. *Periurethral Abscess.*—In the presence of a tight urethral stricture, the mucous membrane of the urethra proximal to the stricture is liable to become ulcerated. This ulceration may spread through the dilated urethral wall and some periurethral infection develop. This is evidenced by a painful brawny swelling appearing at the site of the stricture, which eventually bursts in the perineum, discharging pus and urine. At each act of micturition most of the urine will be passed through this so-formed fistula. The treatment is to fully dilate the stricture and allow the urine to be drained away through an indwelling catheter until the fistula has closed.

2. *Ulcerating Carcinoma of the Urethra.*—Recently there have been two cases in the wards of the Hospital in which epitheliomata of the urethra starting in the middle of the penile urethra have ulcerated to the surface and produced a urinary fistula. These are not common, the majority of carcinomata of the penis developing on the glans penis or around the external meatus.

The Doctor's Dream

A CHRISTMAS EVE FANTASY.

SOME years ago I passed the Christmas holidays with an uncle of mine on his farm in Yorkshire, and we spent Christmas Eve at the local doctor's house. After supper we all sat round the fire talking, the doctor taking particular interest in me when I told him I was going into the medical profession and would shortly be entering Guy's. This latter remark pleased him greatly, for he himself had been a student at the Hospital thirty years previously.

"I remember a curious thing that happened to me one Christmas Eve when I was at the Hospital. It was a queer experience and I can still remember every detail of it," said the doctor in a musing way.

"Oh, do tell us all about it," said my cousin excitedly, "particularly if it's creepy!"

"Very well," said the doctor, lighting his pipe. "I'll have a shot. As I said already, it happened on Christmas Eve. I was on duty at the Hospital and, for some reason or another, was in the very lowest of spirits, for most of my friends had gone off to their homes for Christmas, but I could not get away. I thought that perhaps I should find more congenial and convivial company in the Borough, and so out I went, passing through a dim and quiet Colonnade, out into the windy streets of the Borough filled with a few folk hurrying home before the smelly gusts of wind that came twisting up from the river. There

were a few ragged pieces of humanity sheltering in doorways revealed by the flickering gas-jets.

" Once inside ' The George ' my spirits did not rise much higher, for it was nearly deserted apart from two seedy young men asleep by the fire which was nearly out. I ordered some ale and took a place by the fire on the opposite side to the young men whom I took to be a couple of lads from the Market.

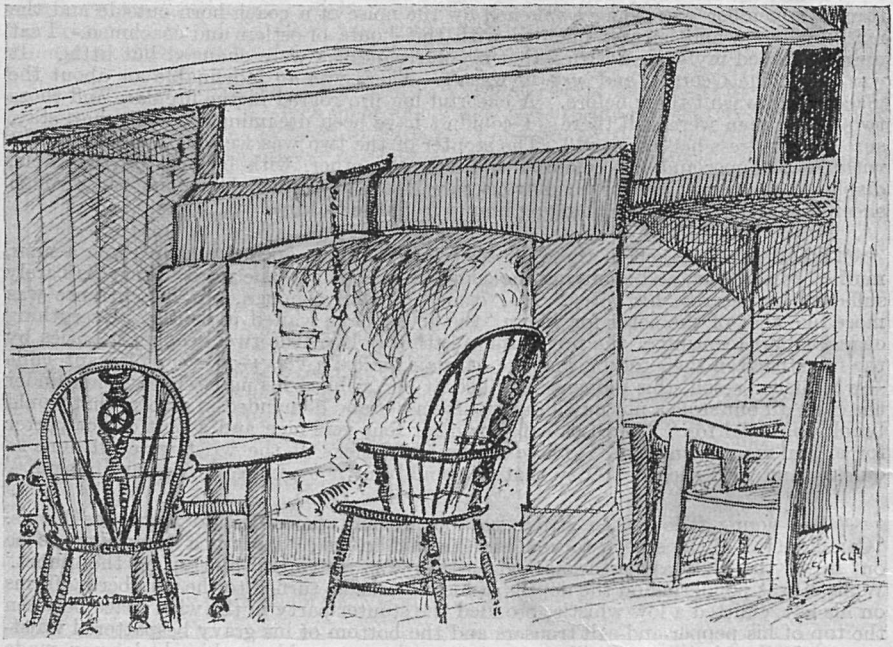
" Either the ale was particularly strong or else I fell sound asleep, for the next thing I remember was being awakened by the noise of a coach-horn outside and the noise of horses and harness mingled with the shouts of ostlers and coachmen. I sat up and rubbed my eyes, noticing that my surroundings were changed but little. It was still ' The George,' and yet it wasn't. There was an indefinable air about the place which wasn't there before. A cheerful log fire roared in the fireplace and those two young men were still there. I couldn't have been dreaming after all—but, stay, surely their dress had changed ! The stouter of the two was wearing a black surtout with tight pepper-and-salt coloured trousers; the other, with his feet on the table, displayed an elegant pair of plaid trousers with a cigar, which had gone out through sheer exhaustion hours ago, hanging limply from the full lips.

" I had barely taken in these details when the door opened and in came a man, muffled to the ears, and stamping the snow off his boots. The word ' came ' is barely sufficient to describe his entry. He ' came ' certainly enough, but his entrance was more like that of the actor for whom ' the gods ' have waited patiently. Everything changed imperceptibly ; the fire burnt a little brighter, the two sleeping beauties by the fire stirred in their torpor, and the barmaid smiled a very—oh, very pleasant smile —when this person, this influence, winked at her, rubbed his nose, chucked her under the chin, all but stole a not unwilling kiss from her and demanded in a voice that would brook no denial for " a bowl of hot punch for four genl'men and a pint of hot porter for a genl'man's genl'man." These winks and knicks of the wrist were all done so quickly and with such dexterity that one could but not admire the owner of them.

" The young fellow then strode to the fire and proceeded to warm his hands. ' Compliments o' the season to you, sir,' he said to me ; ' but's it a dirty night to be out in, as the highwayman remarked as they was a-stringin' him up on the gibbet.' Whilst I was pondering on the depths of his remarks he turned to the slumbering forms on his left, emitted a low whistle, prodded the stouter party in the wide space between the top of his pepper-and-salt trousers and the bottom of his gravy bespattered waist-coat. ' Vell, this is a partickler surprise, as the man said ven his old 'ooman made him a gift of tripods. How is the honourable trade, genl'm'n ? ' Whereupon both ' gen'l'm'n ' woke up, groaned and rubbed their eyes, the taller nearly swallowing his cigar in the complicated process of regaining consciousness, their antics meanwhile causing their awakener the deepest delight. ' Why, Sam,' said the stout party throatily, ' I thought you and your master were at Dingley Dell.' Meanwhile his friend had relapsed into coma again. Sam was about to reply when the door opened and in came four travelling overcoats of differing size and shape. The coats proceeded to execute a strange war-dance before the fire and then to unwrap themselves to reveal their contents which, if you have not already guessed, were the Pickwickians, their inimitable selves: the benign Mr. Pickwick; the fearless hunter of wild beasts, Mr. Winkle; the soulful Mr. Snodgrass ; and, lastly, the susceptible Mr. Tupman, already bestowing glances on the comely barmaid.

" Sam Weller drew Mr. Pickwick's attention to the two forms which had again resumed the unconscious state immediately broken by the appearance on the scene of the bowl of punch. Mr. Pickwick greeted the two warmly, for it was none other than Bob Sawyer and Ben Allen, those two immortal souls who were vainly trying to keep awake, themselves, the fire and the torch of learning. Under the influence of the punch, spirits rose, tongues were loosened, eyes sparkled and the colour mounted to their cheeks. Many were the stories told, adventures recounted, each one accompanied by winks, nods, nudges of the elbow and terminated by gusts of laughter. Finally, Bob Sawyer rose very unsteadily and carefully to his feet and toasted Mr. Pickwick ; at least it must have been that worthy gentleman, for he kept on muttering, ' Gen'l'm'n. Mister Pig—stick. Mister Stick—quick. Mister Pick——" Having delivered himself of these momentous words he swayed back into Mr. Allen's ever-open

arms. He deposited him unceremoniously and unconcernedly in the big chair. Then, steadying himself on the back of the chair, Mr. Allen gravely issued an invitation to the Pickwickians to an informal supper in the Hospital. 'Christmas Eve, y'know. Capital set of fellows. Every one of 'em can drink his own volume of ale time-over without the least disturbance. Never was such a place for self-expansion and waterproof ideas Capital joke that, eh ? Ha ! Ha ! '



" Mr. Pickwick, whose benignity and *bonhomie* were now at their peak, accepted the invitation on behalf of his friends, fully conscious of the deep honour bestowed upon them and aware of their unworthiness, etc., etc. And so, picking up their rugs and shawls—and Mr. Sawyer—they took themselves to the Hospital, but not before Sam Weller had manœuvred the barmaid under the mistletoe. Just as the door closed on Sam, a tall bearded figure rose from one of the corner tables which lay in shadow, so that I had not noticed him, for he certainly had not spoken. He smiled at me as he went out of the door, but I noticed that he had dropped something. It was a handkerchief, in one corner of which were the initials ' C. D.' I opened the door and went out. There was snow outside with the marks of horses and carriages that certainly were not there when I came into ' The George.' ' Mr. Dickens,' I shouted—' Mr. Dickens.' There was no sound but for a distant peal of bells from St. Paul's across the river, which was taken up by all the other City churches, ushering in Christmas Day"

There was silence for a space in the doctor's room. Then, after a minute or two : " What did you do with the handkerchief, sir ? " asked my cousin.

" Oh, I kept it as a souvenir in the drawer here ! Look ! " Sure enough, there was a crumpled handkerchief with the initials " C. D " on it.

It wasn't till I was in bed that night thinking of the story that I remembered the doctor's name—Charles Dodgson.

Another Letter from "Sinbad"

MY DEAR BILL,—So you are safe on board; she sounds a shocking old crate, but there are worse ships and in six weeks you will be convinced that your ship has qualities, even if only in the extent of her pitching and rolling, possessed by no other.

You have no time to waste; the refit is coming to an end and, unless you get hold of the Chief (that's the Engineer Officer) you'll put to sea without washbasin, bunk-board, cupboard space, bookshelves or bottle racks. Chiefs and Doc's always get on well together; approach that seasoned man and ask his help. He'll give it; may be he'll natter a bit at first, but if you write down what you want he will tell the dockyard people to get it for you. That is the snag; you don't know what you want and your medical stores have not yet arrived. This is where I can help. You need storage space for at least one hundred and fifty bottles and jars from 1½ to 4½ inches in diameter—that is a minimum. Twenty-five should be 4½ inches in diameter, fifty 3½ inches, twenty-five 3 inches, twenty-five 2 inches and twenty-five 1½ inches. How you arrange the shelves must be your concern. My cabin and sick-bay combined is 11 feet 6 inches by 7 feet at its widest to about 5 feet for about one-third of its length; into this the best part of four packing cases of medical stores have been hidden away, including such items as 40–50 lb. of cotton-wool and 15 lb. or 20 lb. of lint. Insist upon a high bunk-board; nothing saps the confidence more and is less conducive to sleep than to feel the bunk-board coming loose when the ship rolls. The law demands that you have a dangerous drug cupboard with a good lock and you'll find it useful to have a secure place in your cabin. Bookshelves are another necessity; I'll deal with books later. Have as many bookshelves put in as the wall space will allow. See that the sick-bay will lock and make certain that the scuttles (dead lights merchant navy, and windows to you and me) are watertight; otherwise you will be flooded out as soon as you get to sea. Electricity is the Gunner's country and he will send up one of the L.T.Os (Leading Torpedoman) to deal with you. The lighting always needs attention. Have plenty of lights; ships don't lack power and you cannot work in darkness. I have five lights at the moment and none less than 60 watts; at sea these are on a door switch by which the lights go out when the door opens. Although in an emergency you may have to improvise a steriliser, it is always supplied and is essential. It may be possible to use the galley, but no steriliser means no minor surgery, intravenous injections, wart curettage, suturing, etc; it is a most important piece of equipment. The L.T.O. should be asked to inspect its wiring before you sail so as to avoid unnecessary breakdowns. You are entitled to a kettle and it is worth considerable effort to get one, although they are in short supply. Have a good fire put in; you may go to Iceland or Murmansk and even Scapa is a bleak place much of the year.

When your drugs arrive in their massive packing cases you must ask the First Lieutenant for two seamen (two hands); he is the executive officer to whom most of your suggestions about the ships' company go, although you are directly responsible to the Captain. Check the contents as you unpack and return the cases to the nearest R.N. Medical Depot. You will discover that the collection of drugs, tools and equipment seems hopelessly inadequate. Don't waste time railing at the Admiralty; they certainly know all about it—that is your base line. The next move is to go up to the R.N. Medical Depot with a list of what you want. Senior Pharmacists are very obliging people and will both get what you ask and suggest suitable substitutes. Later on you will develop the habit of calling at the Medical Stores at every port and finding out what there is to be had; for instance, in Canada, wooden applicators and spatulas are easily obtainable, while in Britain they are hard to come by. You will need at least three 10 c.c. syringes—one for arsenical injections, one for anæsthesia and one in reserve—three 2 c.c. syringes and one of 20 c.c. The large syringes should have an eccentric nozzle; I have found the official Vim syringe does very well.

Once the stores are on board divide them into two self-contained units one forward (sharp end) and the other aft (blunt end); each must be arranged so that it can carry on should the other be destroyed. Get the Ordnance Artificer to make you eight first-aid tins 10 ins. by 8 ins. by 6 ins., and fill these with a selection of shell and wound dressings, burn jelly, triangular bandages. These and two larger canteens, which can be had from the medical stores, must be put in suitable places round the ship; the boats and the Carley rafts will also require simple first-aid kits. The First Lieutenant is your ally and your adviser in these matters; you may think that he is too young to

be reliable, but since he has probably been at sea for much of the four years of war spending most of the time in little ships, he knows much more about medical organisation at sea than you do. Therefore, ask for his advice and follow it until you have had experience of your own to go upon.

Either the Wardroom or the Captain's Cabin (he lives in isolation just below the bridge at sea) will be your operating theatre at sea, although it is not easy to make extensive alterations without alarming both the Captain and your fellow officers; you should spy out the land and see that light and heat points are suitable for your steriliser, and plan how you would deal with the emergency which might at any time arise. I have had great difficulty in finding space to do artificial respiration by Ede's rocking method. Before you leave Guy's half-an-hour spent in Front Surgery will enable you to teach your S.B.A. how to make surgical swabs and sponges, which can be made up in packs of twelve covered in a calico wrapper and sent to the nearest hospital for sterilisation in metal.

In the meanwhile you will be treating patients and the S.B.A. should keep a day-book recording every illness or injury, however trivial, with the man's name, number, age, mess, whether on duty or not. If injured, nature of ailment, examination, treatment and disposal noted in columns. The M.O. keeps case sheets with full history an progress notes of more serious conditions; a card index with a lock is a convenient method of housing these, and the Naval Store Officer at base will supply them on demand. If the Official Medical History sheets are carried on board you will require considerable space in which to store them.

While you are arranging the various points mentioned above, you will have to start equipping yourself for the sea. In a small ship during the winter months there is no surer way of leading a miserable life than being inadequately clothed. The M.O., not being a watch keeping officer, comes low on the list for protective clothing, but as you will have to traverse the upper deck at least ten times a day when it may be constantly awash with the air temperature below freezing, it is wise to be dressed properly.

You will be provided with a certain amount of loan clothing, some sweaters, a rubber life-belt, a pair of gloves, an oilskin, a duffel coat and a pair of sea-boots. The duffel coat makes a useful dressing-gown and is pleasant to wear on the very rare cold, calm, dry days, but it is seldom suitable for a small ship. It becomes soaked with water and dries slowly, picks up dirt easily, does not keep the legs and thighs warm and the hood interferes with vision. The life-belt is better replaced by a kapok-filled zip jacket with capacious pockets; research on blast suggests that it could be extended to the level of the pubis and so give protection to the abdominal viscera from under-water explosions. The best sort of gloves I have yet seen are Canadian ones which have an outer horsehide mitten and an inner woollen one; this can be dried without scorching and cracking the leather. You can never have too many woolly clothes; surplus may always come in useful for survivors, and you will often get soaked yourself and need a change, oilwool socks and stockings, sweaters, scarves, balaclava, woolly skull cap or beret, and at least one suit of long woollen underwear whose appearance may be a trifle *fin-de-siecle* but will be a great comfort. Battle-dress, which has been worn by all officers for the last four years and has just been recognised officially can be bought at an outfitter's for £5 or so; if you can procure an Army one and have it dyed it will be much cheaper; this may be heretical. You will find a pair of oil-skin leggings, sea-boots, an oikskin coat and a large sou'-wester or a hood made an excellent kit for traversing the deck, but if you should pick up survivors from a U.S. ship you may be lucky and get one of their luxurious black rubber suits. Everything except your face is enclosed in black; the effect is reminiscent of Dracula.

On top of everything goes a rope harness; early on you should persuade one of the quartermasters to make you one of these; it is to assist your rescuers should you be sunk and attached to it is a police-whistle to attract their attention and your clasp-knife kept fairly sharp. Since this gear will take up a good deal of room get a kit-bag from the slop shop in which you can store it.

Next time I will deal with some points about books and instruments and how to avoid being washed over the side or otherwise incapacitated during the first weeks at sea.

From your companion, who found out the fool's way, learning by his own experience, instead of from someone else's.

Your un-nautical sea-leech,

SINBAD.

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Reviews

Forsdike's Textbook of Gynæcology. Edited by J. H. PEEL. Published by Messrs. Heinemann. *Price* 21*s.*

THE original edition of this work had long been regarded as much out of date, and Mr. Peel has done his best to revise the book and bring it into line with modern teaching while still retaining the original framework. The number of illustrations has been greatly increased. Unfortunately, the quality of the photomicrographs is in many cases bad, lacking any detail of cell structure. Many of the sections illustrated are unidentifiable, due to bad processing and too heavy printing. In contrast to these there are a large number of beautiful black-and-white drawings of sections which are in all respects admirable.

The text is a good introduction to the subject and the chapters on treatment are concise and conservative. The section on radiotherapy is good, and its conclusion with notes on the possible disasters of unskilled use of radium is a salutary warning.

Generally speaking, the book is one of limited use. As a pure " cram " book it is too large and as work of reference it is too small. But it has for years enjoyed a certain favour as an introduction to the subject, and in its new garb will doubtless continue to do so.

But why in a short book for students should it be deemed necessary to devote two illustrations to Xanthofibroma theca cellulare, an ovarian tumour of extreme rarity, which is of interest only to endocrinologists and professors of pathology ? J. K. B.

Chest Examination : The Correlation of Physical and X-Ray Findings in Diseases of the Lung. By RICHARD R. TRAIL, M.D., F.R.C.P. With a Foreword by SIR WALTER LANGDON-BROWN. M,D,, F.R.C.P. *London :* J. and A. Churchill, 1943. Illustrated. Pp. 107. *Price* 10*s.* 6*d.*

THIS little book is divided into four sections : firstly, a reminder of the normal anatomy and physiology connected with respiration ; secondly, the applied pathology of common respiratory diseases ; thirdly, a summary of the physical signs discussed in the second section ; fourthly, some points in the interpretation of abnormal X-ray films, which should be very helpful.

The pathology is unorthodox and not altogether sound, and appears to be built up on the consideration of X-ray films rather than on morbid anatomy. Clinical signs are interpreted so dogmatically that the reader is given the impression that a full physical examination gives such a complete result that X-rays and sputum tests are no longer necessary. No fancy signs such as *bruit d'arain* (bell sound) are mentioned, though from the student's point of view, he may be expected to know about these in his Finals. There is omission, however, of a more important practical possibility which often perplexes the student ; the fact that loud bronchial breathing may sometimes be heard over a large pleural effusion. The latter is apt to be associated with a considerable pyrexia, and so diagnosed as pneumonia, and often, in these days, wrongly treated with sulphonamides.

The author lays particular stress on the increased tension in the tendinous portion of the sterno-mastoid muscle on the side towards which there is mediastinal displacement—the sterno-mastoid sign. For instance, he states that it is *always* positive on the affected side in collapse of the lung in all its forms, and that " it is a much more reliable finding than *any other aid,* even including that of screening."

However, the book should stimulate those who read it to go on trying to learn more from a careful analysis of physical signs, but they would be wise to come to their conclusions of the interpretation and reliability of their findings by repeated checking with X-ray examination, sputum tests and, whenever possible, morbid anatomy.

Lastly, it must be borne in mind that though no abnormal signs may be detected, and indeed even no symptoms may be present, yet disease in the chest may exist which may be revealed by X-ray examination. E. B. F

Photo D.P.W.

Back row.–C. Gadney (Ref.), A. C. Macrae-Gibson, R. A. Dean, D. C. Boyd, D. L. Gullick, G. Hildick-Smith, P. D. Harvey, P. C. Alexander (Touch Judge)
Seated.–C. Ziervogel, D. M. Strathie, C. Vidot (Vice-Captain), W. D. Doherty (President), A. B. Lee (captain), A. Batty-Shaw (Secretary),
R. G. L. Brittain, N. K. Macrae-Gibson, *In front.*–R. D. Willcock, E. W. Graham.

Sport

Rugby

GUY'S HOSPITAL *v.*
PAST AND PRESENT RUGBEIANS.
(*Played at The Close, Rugby School, on December 4th, 1943.*
Guy's Hospital, 12 points;
Past and Present Rugbeians, 6 points.

At the kind invitation of Rugby School, Guy's Hospital XV had the honour of concluding their centenary celebrations with a match on The Close at Rugby. In 1923 England and Wales played Scotland and Ireland on this ground, where, one hundred years previously, William Webb Ellis "with a fine disregard for the rules of the game as played in his time first took the ball in his hands and ran with it." Rugby gave us a great welcome. The Housemasters invited us to lunch; the band of the Royal Warwickshire Regiment played before the match. There was a crowd of over 1,200 and the weather was perfect for a game of Rugger. Guy's had intended to field the same side as had played on the previous Saturday, but several old Rugbeians could not get away at the last minute and so D. M. Strathie and A. Batty-Shaw played for the opposition. The Hospital won the toss and chose to defend the Doctor's Wall—a Rugbeian phrase—but this wall in front of School House contains the commemorative tablet to Ellis. The powerful Hospital pack got possession of the ball from most of the scrums and had much the better of the play. Graham got the line moving well, and A. C. Macrae-Gibson scored after a neat passing movement. Shortly afterwards Walford failed with a drop kick for Rugby. Then Graham burst through for another try for Guy's, and this lead was increased when Gullick went over early in the second half.

The Rugby side then settled down and their light pack gave the backs more of the ball. Strathie went over on his own for a brilliant try, and this was soon followed by Walford going over in the corner. Williams, a present Rugbeian, was unlucky not to score on the left wing, and once Strathie broke right through with no one to pass to. In the final minutes Willcock made certain of a victory for Guy's by slipping over from a scrum on the Rugby line. Willcock and Graham, unhampered by club wing-forwards, played well and Hildick-Smith, with faultless positioning, was excellent.

After the match the two teams were the guests of the Headmaster at a dinner held in the School Sanatorium. Of the Guy's men present there were Mr. J. E, Humphery, LL.D., chairman of the Court of Governors at Guy's; Air-Commodore Conybeare; Mr. Blaikley; Mr. Wass; Dr. R. E. Williams; Dr. Meacock; Flying-Officer Gilbert; Dr. Carnegie; and Dr. R. E. Smith, who had done so much to organise the arrangements.. Mr. James Gilbert, whose name is familiar on Rugby footballs, was also there. We would like to record our thanks in particular to the Headmaster, Major Keay and all at Rugby for their kindness and hospitality on this memorable occasion. Those members of the side who spent the night in the Sanatorium were brought breakfast in bed the next morning. It was a great week-end.

Teams.—Guy's: G. Hildick-Smith; D. R. Edwards, D. C. Boyd, N. K. Macrae-Gibson, A. C. Macrae-Gibson; E. W. Graham, R. D. Willcock; I. Hilliam, A. B. Lee (captain), R. A. Dean, C. Ziervogel, D. Gullick, P. D. Harvey, C Vidot, R. G. L. Brittain.

Rugby School Past and Present: C. A. Pridmore; N. J. D. Williams, D. M. Strathie, M. M. Walford, G. W. Myrddin-Evans, J. A. Boyes, W. S. Wardill; M. R. Steele-Bodger, N. R. Power, R. H. A. Power, A. Batty-Shaw, P. J. R. Schlee, R. J. Overton, M. J. Hussey, N. R. H. Owen.

Hockey

GUY'S *v.* KING'S COLLEGE HOSPITAL.
(*Played at H.O.P. on Saturday, December 11th.*)
(Won 6–1.)

In this game Guy's had much the better of the play during the first half and established a lead of 5–0. This was largely due to remarkable finishing by Doyle, who convincingly scored four of these. After half-time, rather naturally, Guy's became more easy-going, so that King's College came near to scoring several times, though, in fact, they scored only once. Our half-back line was outstanding. Parr, as always, gave his man very little chance, and Carton-Kelly, on the other side, performed prodigious feats with one hand, thereby increasing his already long reach.

Team.—A. C. Campbell; D. C. Dawson, B. H. Prideaux; L. D. Carton-Kelly, J. G. Richards, P. T. Parr; C. J. Jenkins, A. E. Doyle, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

GUY'S *v.* LONDON HOSPITAL.
(*Played on Saturday, December 18th.*)
(Won 8–1.)

The rather devastating score perhaps does an injustice to our opponents' capabilities. For the first time this year Guy's really combined well and the forwards by dint of clever passing brought the ball up to the circle time and time again. On the whole their shooting was poor, and many easy chances went wide or merely trickling up to the goal. Burt scored an unexpected goal from the bully off without anyone else on either side really touching the ball. He scored three more later in the game. There were some fine runs by the wings and Wotton sent in many strong centres, from the left, which is always very difficult.

Team.—A. C. Campbell; D. C. Dawson, B. H. Prideaux; L. D. Carton-Kelly, J. G. Richards, P. T. Parr; G. Thompson, T. C. L. Parry, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

Association

GUY'S *v.*
UNIVERSITY COLLEGE HOSPITAL.
(*Played at Richmond on November 27th.*)
Won 5–1.

During the first half in this London University League match Guy's was held by the U.C.H. defence. The Guy's forwards made several dangerous attacks on the opposing goal, but only scored once, and soon afterwards U.C.H. drew level. At half-time the score was 1–1.

In the second half the Guy's side pulled itself together and had all the play. The forwards attacked strongly, but more often than not the ball came in from the wings too late, thus enabling the U.C.H. defence to take up position. However, Sykes nodded in a neat goal from a perfect corner kick by Stableford.

Clarke, playing centre-forward, kept the U.C.H. defence hard stretched and scored three useful goals. The last goal scored by Tuite made the final score 5–1.

Team.—A. G. Starte, E. G. Murphy, N. T. MacNeil, S. Stableford, R. D. Rogers, C. S. Mathews (captain), W. R. Hall, M. J. L. Sykes, C. B. Clarke, A. E. Triste, R. Owen.

"Ten-Minute Alibi" at Tunbridge Wells

WE, at Tunbridge Wells, on December 10th and 11th, 1943, saw a magnificent production of "Ten-Minute Alibi" at the Convent of the Sacred Heart by the Students' Dramatic Society. Hard work on the part of the producer, Dennis Forsdick, was evident from the well-polished performance and the ease with which one could follow the twists of this intricate plot, his task being made doubly difficult by a recent offensive of the influenza virus. The question arose as to whether this play was better than "Rope," which was produced last Christmas and everyone agreed that, although "Rope" was good, this play was better—a generally higher standard of acting and remarkably good scenery in spite of increased difficulties. J. G. Stebbing, D. S. Hurwood, P. R. Wagner and others constructed practically all items of equipment in their spare time.

Tony Brewin as Detective-Inspector Pember was excellent. His artificial limb was no handicap to his very adequate presentation of the "old school" detective. His junior, Detective-Sergeant Brace, a young "staff college" policeman was played by Colin Watson, whose sound technique gave Brewin every opportunity to give of his best. The oily seducer, Philip Sevilla, was well portrayed by John Hayward. Betty Findon, his latest capture, was delightfully played by Daphne Glasgow and the love scene which opens the play and which is usually so painful in amateur productions was very well done. Michael Coplans, who appeared last year in "Rope," made a good job of Colin Derwent, the murderer. His cool headedness during the dream scene was well contrasted with his nervousness during the actual murder. Raymond Luffingham played Sir Miles Standing, an imposing legal personage and caused, considerable amusement amongst our left-wing colleagues by inferring, when accused of the murder, that he could not have been responsible because he was a member of the Conservative Party. Hunter, Sevilla's "old lag" manservant, was played by Joseph Carreras and G. L. Barnard, was a pupil of whom Father Time might well have been proud.

Those present included the Dean, Mr. and Mrs. Spurrell, Dr. Whillis, Professor and Mrs. Fenn, and Dr. and Mrs. Haslewood. Miss MacManus, who came down for last year's show was, unfortunately, unable to be present. Dr. Grasby, medical superintendent of Pembury Hospital, was there with Mrs. Grasby, and many thanks are due to the producer and the whole company for a very delightful show. C. T.

Guy's Odd Ode No. 1

This is the tale of Gertie Grice,
Who came to Guy's because her face
Had come all out in purple blotches.
Her friends said: "It's those double Scotches."
She asked her doctor for a letter
Because he couldn't get her better.
Ses he: "Well, Gert, if you insist,
You'd better see a specialist."
So Gertie, full of grateful hope,
Washed right behind the ears with soap;
And, as she didn't want to wait,
Had got to Guy's by half-past eight;
And, after wandering through the Park,
Was told to see the appointments clerk.
Says Gert: "Now I've come all this way
D'yer mean I won't get seen to-day?"
The Sister answered: "Don't you fret,
My girl; you ain't seen nothing yet.
Our O.P.D. appointment scheme's
The answer to a maiden's dream.
Don't grumble; all you have to do
Is take your turn—so join that queue.
The end is somewhere in the Park,
And then you'll see the appointments clerk."
So Gertrude, feeling rather glum,
Stands waiting for her turn to come,
Until at last she's told to go
And see the student O.P.O.

Poor chap! Perhaps one ought to say
He hoped to qualify by May.
And when our Gertie came in view
Had seen some cases—thirty-two.
Missing his lunch and now could see
That Gert might make him miss his tea.
"My face," she said, "is something chronic.
D'yer think I need some kind of tonic?
I've 'ad it for a decent while;
It goes all goosey when I smile."
"Don't worry!" cried the O.P.O.
"The treatment's one I chance to know.
Your trouble's simply endocrine.
Now take this stuff and you'll do fine."
And so our tale is nearly through;
Gert did as he had told her to,
And daily gazes in her glass
To see the purple blotches pass.
And, true, they soon began to clear;
But Gertie runs to Guy's in fear
And at the O.P.D. appeared
Complete with a moustache and beard.

The Motto.

If you're out for fun
First learn to walk before you run;
And if you're doubtful what to give,
Better prescribe a laxative!

ANON.

Hospital Information, etc.

Notices

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of Demonstrator in the Department of Conservative Dental Surgery. Attendance six sessions weekly from 9 a.m.–12.30 p.m. Salary at the rate of £360 per annum. The appointment will be in the first instance until September 30th, 1944. Candidates must hold a registrable qualification, and must be ineligible for service with H.M. Forces. Applications, accompanied by three testimonials, must be sent to the Dean, Guy's Hospital Dental School, London Bridge, S.E.1, by January 12th, 1944.

T. J. EVANS,
Dean.

THE TREASURER'S MEDAL & PRIZE IN CLINICAL SURGERY, 1944

The following award has been made:—
P. G. Large, Medal and Prize.

Pass List

UNIVERSITY OF CAMBRIDGE.
FINAL M.B. EXAMINATION.
Michaelmas Term, 1943.
PART I.—Surgery, Midwifery and Gynæcology.

P. L. Blaxter	L. L. McKelvie
D. W. Burnford	M. W. L. Mutch
I. S. Hodgson-Jones	J. F. N. Sidebotham
R. E. Irvine	D. P. Wheatley
J. Lorber	

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
F.R.C.S.
FINAL EXAMINATION.
November, 1943.

D. M. Jackson	H. D. Drury

EXAMINING BOARD IN ENGLAND
PRE-MEDICAL EXAMINATION.
December, 1943.

Chemistry.

M. W. Harber	D. W. Leatherbarrow

Physics.

M. B. Lacey	A. P. Rowland
N. E. McIntyre	R. B. Tustian

Biology.

M. B. Lacey	N. E. McIntyre

Change of Address

J. G. Hancock, Capt., A.D. Corps, 95 General Hospital, B.N.A.F.

G. L. B. Thurston, Lt.-Col., R.A.M.C. 17th British General Hospital, India Command.

Marriages

BEARE—WATSON.—On November 17th 1943, Surg.-Lieut. R. H. Beare, (I R.N.V.R., to Helen Mabel Watson, S.R.

HUMPHREY—BOOTHMAN.—On December 4th, 1943, at Pembury Parish Church Edward Albert Humphrey to Irene Boothman.

Deaths

BRERETON.—On December 15th, 1943 at 4, South Drive, Gidea Park, Essex Frank Brereton (23 years Works Dept Guy's), aged 59 years.

EDS. {D.R.S.
J.P.M.}